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AUTHOR Gaumer, Nancy; And Others
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ABSTRACT

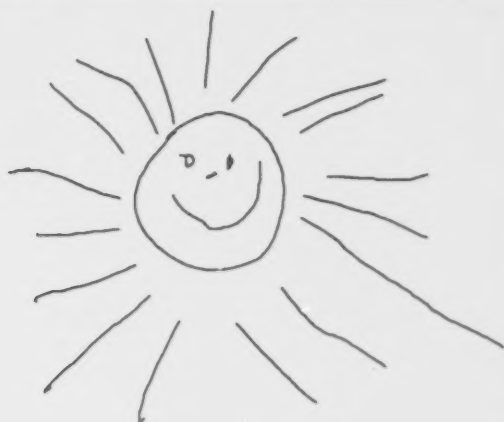
This manual provides guidance on using the consultation method to help meet the needs of families of children with disabilities in integrated community-based day care settings. The introductory section provides an overview, a statement of philosophy, the history of the day care consultation program in Illinois, and instructions for using the manual. Covered in Section II, on procedures, are: the consultation model and process; communication skills; recruiting caregivers for children with special needs; supporting child care providers; attitudes; placing children with special needs in groups; staff-parent conflicts; the regular vs. special education dilemma; multiple service providers; and strategies for integration. Topics covered in Section III, on families of children with special needs, include the effects of having such a child, day care for children with special needs, day care and family support, choosing and using child care, and siblings of children with special needs. Section IV presents guidelines for developing five workshops on the following topics: (1) identifying children with special needs; (2) introduction to handicapping conditions; (3) communication skills; (4) behavior management; and (5) family involvement. Section V contains separate modules of materials concerned with high risk children and children with hearing, visual, motor, speech/language, cognitive, health, social, emotional, and behavioral needs. Handouts and supplementary materials are also provided. Two glossaries list special needs terms and abbreviations. (DB)

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Day Care for All Children

*Integrating Children with Special Needs
into Community Child Care Settings*

a resource and consultation manual



developed by:

Nancy Gaumer, *project director*

Helen Shapira

Beverly Lewman

Kay Erwin

Lori Morrison

Jan Lang

Patti Harrod

Dale Fink

Nancy Yeagle

Anita Urborg

Becca Nowak

Brenda Cox

Roch Ducey, *manual design*

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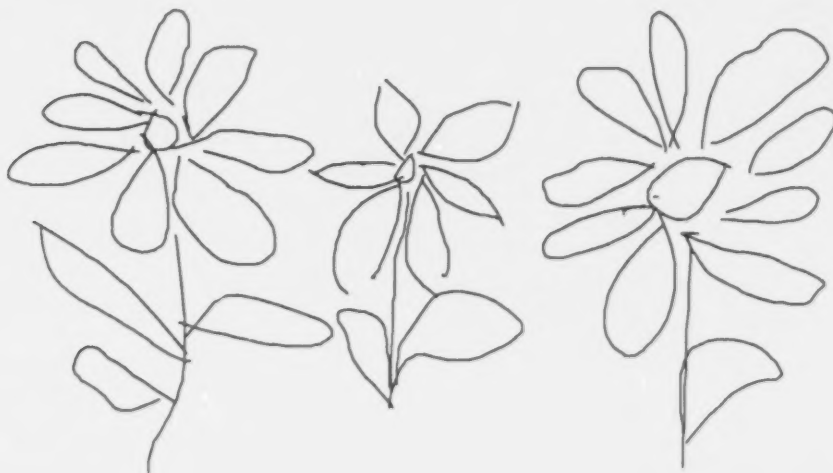
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This manual is dedicated to Joshua, John, Jolie, Elizabeth, Laura, Matthew, Jeramey, Christopher, Emmy, and all the children who taught us how to walk, talk, and hear.



Day Care for All Children

*Integrating Children with Special Needs
into Community Child Care Settings*

a resource and consultation manual

Preface

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Preface

Day care providers are finding more and more children with special needs in their programs. This trend is expected to continue as the total number of children with special needs increases. Numbers of children with special educational, physical, and social-emotional needs are related to two primary factors—the problem of substance abuse and the fact that more and more children who previously would not have survived birth are now being saved due to the advances in neonatal intensive care in the last ten years. Not only are the numbers increasing, but the severity of the needs are increasing as well. Maternal drug use and other conditions leading to stays in intensive care nurseries can cause impairments ranging from attention deficits to severe cerebral palsy. These impairments have long-range consequences for the child. Child care providers are in a unique position to help identify the special needs a child may have.

The child abuse and neglect problem is also on the rise. Not only do these children have physical needs resulting from abuse, but they also have some very special social and emotional needs. Day care is often provided to families as a way to provide support in times of stress and crisis. It is important for providers to be aware of the needs of this population of children, and how they can best support the child and his family.

Many working parents have children with special needs. A great percentage of these children are receiving day care services outside the immediate family. Children birth to three are usually in day care for the biggest part of their waking hours. Children three to five usually attend a special education program for only three of the nine hours (including travel time) that parents usually work. The remaining six hours (two thirds of their time) are spent in day care. Children over five may need day care for three or more hours per day during the school year. The number of hours in day care can increase signifi-

cantly if parents work nontypical hours (nights, weekends, split shifts). The great majority of children with working parents will need full time day care in the summer months. It is unreasonable to think that early intervention and special education programs that do not consider a child's day care experience/hours in programming are meeting the needs of the whole child and his family. Because of the reality of children's lives today, we cannot separate education from day care.

The Illinois Department of Children and Family Services requires that day care center providers cooperate in the child's educational program. Licensing regulations require that centers: a) consult with resource personnel and consider their recommendations in planning activities for the child, b) develop a program plan for the child, c) keep in close contact with parents, d) obtain school records on the child, e) receive in-service training that relates to the specific needs of the children served, and f) when a facility serves 8 or more children with special needs, the staff directly responsible for planning and coordinating their activities should have college courses in normal child development and working with exceptional children. (See reprint from standards at the end of this section for a more complete listing of requirements.)

This manual provides guidance on using the consultation method to help meet the needs of families of children in day care. This method is not the only way to meet the needs of families and children, nor is it the best way for all children. It does, however, provide a framework for inter-agency or multiple service provider collaboration that is easily adapted to a variety of settings and ages of children.

LICENSING STANDARDS FOR DAY CARE CENTERS

Section 407.26 Children with Special Needs

- a. A center receiving children with special needs shall comply with standards for all day care centers except when inconsistent with special requirements prescribed in this Section.
- b. There must be written evidence on file that resource personnel with appropriate expertise have been consulted and their recommendations considered in planning program activities for children identified as having special needs.
- c. Recommendations made by the resource personnel and designed into a program plan by the resource team for the child with special needs shall be implemented. The resource team shall consist of the director, direct child care staff, and registered, licensed, and/or certified resource personnel such as physicians, psychologists, social workers, speech therapists, physical and occupational therapists, educators, and other technical and professional personnel, as indicated by the child's special needs.
- d. All program recommendations from resource persons related to a child's special needs shall be evaluated and reviewed at least twice a year.
- e. Parents shall be fully informed and in agreement with all procedures undertaken in relation to the child's needs.
- f. When a facility agrees to accept a child with special needs who attends school, school records shall be obtained by the facility, and communication with school personnel and parents regarding the child's special needs and progress shall be maintained.
- g. Building and equipment shall be designed so that every child can make maximum use of the facility as safely and as independently as possible.
 1. The facility areas to be utilized by a child with special needs shall be adapted as necessary to accommodate special devices which may be required to function independently.
 2. Minimum space requirements per child with special need(s) shall be 35 square feet.
 3. A special area shall be maintained for the purpose of providing privacy for diapering, dressing, and other personal care procedures.

- h. Persons rendering special professional services to these children must be registered according to state, registration and/or certification laws currently in effect, if applicable, or must function under the direction of a person so qualified. (See Appendix E for professions requiring license or registration.)
- i. When a facility serves eight or more children with special needs, the identified staff person or persons directly responsible for planning and coordinating activities for these children shall have achieved training at the college and/or university level which include:
 - 1. A course that deals with normal child development;
 - 2. A course that deals with problems and treatment of exceptional children.
- j. The staff serving children who require special program services shall receive inservice training that relates to the specific needs of the children served.
- k. When children with special needs are served as a group, the ratio of child care staff to the number of children served shall be 1:4. This ratio excludes student helpers under 18 years of age and adults who are also served in the program.
- l. Medical consultation and direction shall be available to staff. Other medical services, such as direct medical care to the child, shall be administration of any and all prescribed medicine.
- m. Individual records shall be made available to parents and shall include information needed to assist the staff in planning effectively to meet each child's needs, and shall be kept confidential. No record or portion thereof shall be transferred without written parental permission.
 - 1. The individual records shall include:
 - a. All assessments;
 - b. Program recommendations;
 - c. Program provisions to meet recommendations;
 - d. Program evaluations; and
 - e. Program adjustments as indicated by the evaluations.
 - 2. Facilities shall make known to the parents that records are available.

LICENSING STANDARDS FOR DAY CARE HOMES

Section 406.20 Children with Special Needs

- a. Children identified as having special needs shall have activities relating to those needs that are planned with parents and/or consultants.
- b. There shall be suitable space and equipment so that the child can function as safely and independently as possible.
 1. Areas of the home shall be adapted as necessary if special devices are required for the child to function independently.
 2. Space needs shall be determined by considering such factors as age and size of the child, activity recommendation, and ambulation problems.
- c. In determining license capacity, children who have special needs due to physical, mental, and/or emotional disabilities shall be considered at the age level at which they function. The age level at which the child functions for purposes of determining child/staff ratios shall be determined by the supervising agency in consultation with personnel involved in providing care or services for the child.

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Section I - Introduction

BEFORE YOU BEGIN

As you read this manual, you may have many doubts about your own ability to handle the challenges involved in serving children with disabilities in community-based child care settings, or in helping others to handle them. This is natural; doubt and anxiety usually accompany the learning of any new set of skills, regardless of how old or accomplished you are. The following fictionalized case study will take you, step by step, through the process of integrating one four year-old-girl with developmental disabilities into a community-based child care setting—and help you realize that you can do it too. This case study should be shared with any staff members who are going to be involved in this kind of process. It shows the kinds of things that you—or they—are going to be doing as you develop your own plans for integrating children with special needs.

Although your setting, age grouping or available resources may be entirely different from what is depicted here, you will find that the kinds of questions to be asked and the key lessons learned remain largely the same.

In a sense, everything else that follows in the manual is designed to enable you, or those with whom you will be working, to one day write your own story about your own Tanika—whose name may be Jamal, or Elizabeth, or Vicente, or Carmen. We hope you enjoy reading the story of Tanika. And we hope you also enjoy the newfound expertise this manual will help you to achieve.

THE STORY OF TANIKA

I can still picture the moment the social worker entered the room. I had just finished repainting the cubbies, and was marvelling at how well prepared I was for my new group of four-year-olds. Now, at the last minute, there was to be another child added to our enrollment.

"Tanika has some special needs," he told me.

"A handicapped child?" I asked, pretending not to be horrified."

"She'll be coming to your classroom three full days and two afternoons a week. The other two mornings she'll be in an early childhood special education class at the public school, so it will be important to have close communication with the staff over there as well."

"Close communication?" I thought to myself. "Between me, a homemaker who became a day care teacher without ever going to college, and the public school staff, with their advanced degrees and their fancy terminology that will probably go right over my head?" That's what I thought. But all I said was, "What good will it do her to be in our class? We've never had a handicapped child."

"Tanika needs to be in a program with children who are functioning normally. She needs opportunities to learn language and social skills. I told them your classroom would be perfect for her."

When he put it that way, it did make me feel a little better—but underneath, I was still scared out of my mind. Little did I know that within a year I would consider the entrance of Tanika into my classroom the best thing that ever happened. Or that thanks to her, I was going to become confident about handling all kinds of things I never knew I could master.

The first thing I learned was about language, and I learned it that very first day. The social worker explained—in his gracious, nonjudgemental way—that it was better not to refer to Tanika as a "handicapped child," but rather to say she had developmental delays. I had never known that the word "handicapped" came from begging for money with a "cap in hand;" once I learned that, it was easy to stop using that term. Following are some of the other important things that I and my co-workers learned during our year with Tanika.

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Gather information from many sources, and be sure to ask about the children's abilities—not just their disabilities.

Our best source of information was Tanika's parents. We learned from them that her developmental delays stemmed from cerebral palsy, which meant that some kind of trauma had taken place while she was still developing in the mother's womb. They explained that cerebral palsy affects each child differently. In Tanika's case, she had had to undergo heart surgery, and was generally slow to develop physically and cognitively. They also explained that she was not yet toilet trained, did not dress herself, and did not yet play well alone. They also told us about the many things that Tanika could do and how they got her to do them—what they said and what cues they gave her as reminders.

The first visit to the public school was not nearly as traumatic as I had expected. Tanika's teacher there explained what skills they would be working on, showed me some of their equipment, toys and material and then introduced me to the speech, occupational, and physical therapists. Each of whom showed me examples of the kinds of things Tanika might be doing with them, and told me how often she would see them. They emphasized that in our environment Tanika should be encouraged to play and to do things she liked to do—that I didn't have to feel like a trained therapist who was constantly helping her with a specific skill. I breathed a sigh of relief when I heard that.

A developmental approach works for all children, regardless of their cognitive level.

In our classroom we had always had a mixture of teacher-directed and free play. We had always felt that many of the best interactions (child-to-child as well as staff-to-child) took place during the periods of active exploration by the children, when we were not focusing on specific teacher-initiated products or tasks. We discovered that for Tanika, these periods of time were by far the best. She could fit in fine when there were different kinds of

materials which children could touch, move, build, transform, or talk about. Large-group, formally structured learning activities had always been frustrating to some of our children; we found they were nearly impossible for Tanika. So we became more developmental and child-centered in our approach, with teachers acting more as facilitators and less as instructors, and providing structure and support for those individual children in need of it (such as Tanika), while standing back from those who were capable of more independent activity.

We were amazed to see that children of all ability levels benefited from this evolution in our format.

Structure success into your routines, your environment, and your materials.

Tanika did not seem to get the hang of washing her hands—until we discovered inadvertently that if she watched eight or ten other children do it, then she would try to do it. From that day on, part of her routine was to come to the sink first and watch everyone else wash their hands before lunch; then she would wash hers.

Because Tanika tired easily, we created a quiet corner with stuffed animals and pillows and gave it a name—the Soft Spot. She wasn't usually able to monitor her own fatigue and go there herself, so staff would suggest to another child at certain times to "do something quiet with Tanika in the Soft Spot." This made for a more balanced environment for all of our children, and she was by no means the only one who used the Soft Spot.

We reorganized our shelves so that the toys and materials Tanika seemed to gravitate toward were in the easiest places for her to reach. We also found that she got very confused if things were not put consistently back in the same places. Her presence thus stimulated us to keep our cabinets and shelves much more organized than ever before, and it proved to be beneficial for many children, and even for the afternoon staff, who used to complain

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a lot about not being able to find things after we got through with them in the morning.

Adapt the environment and materials.

We lowered the shelf and coathook in Tanika's cubby so that she could learn to put things on the shelf and hang up her coat like other children. We bought a plate with a suction cup on the bottom so that she wouldn't knock the food off the plate in trying to use her utensils. We added a footrest to a chair for her, after the physical therapist explained that it would be better not to have her short legs dangling above the floor. With this improved positioning, we observed that her ability to focus on eating and also on other table activities was greatly improved.

We added simpler puzzles to our collection, including some of the wooden kind with knobs on the pieces. You'd be amazed how many of the higher-functioning children also play with these, perhaps at moments when they wanted to feel competent and weren't in the mood to be challenged.

While other children might build elaborate structures with blocks, we began to consider it perfectly all right if Tanika's activity was to take blocks off the shelf—and then put them back on the shelf.

Use task analysis to help children learn new skills—and concentrate on functional skills first.

The term "task analysis" simply means to break any routine into its various steps. With Tanika, some of the steps in "putting on and taking off coat" were the following: Take coat off hook; arrange it on floor; put arms in sleeves; put arms over head, etc. We would not frustrate her by "drilling" on these when she might be playing with blocks or fingerpainting, but would encourage her to work on them when it was appropriate and she was motivated to try them, ie. when we were getting ready to go outside. We would not pressure her to do all the tasks right away, but

praise her for doing the one or two she had mastered, until she was ready for another.

In general, we tried to identify first the skills that would really help her to function as much as possible as a regular member of the group. Practicing pulling her own pants up and down at diapering time or eating without a great deal of assistance at meal time were two very important ones.

When we played games like "Simon Says", we would keep in mind some of the physical motions we were helping Tanika to work on, and would call out "Simon says eat with your spoon", or "Simon says pull up your pants".

All the children enjoyed these commands and never knew they were designed for Tanika's benefit.

Integrate therapy into your setting

We found that lots of children loved doing the things that Tanika was supposed to do with her therapists. For instance, her physical therapist was having her practice pushing and pulling a variety of objects—or another person's body. Letting other children join in made it more fun for Tanika, rather than an isolating experience. Watching these activities also was great for me and the other staff. Therapy was no longer a mystery. Going to an evaluation meeting with several therapists was no longer an intimidating experience, once I had seen them in action, perhaps even on their hands and knees. I now saw them as colleagues who worked in a different way with the same children I worked with.

Observe, observe, observe

Early in the year we noticed that when we thought Tanika was doing "nothing" she was actually trying to imitate the other children. Thus we allowed this to go on for long periods, rather than redirecting her to something more "constructive". Other observations were also critical. We noticed at one point that Tanika was inter-

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ested in dogs, and were able to capitalize on that interest to get her involved in a whole range of play activities and tasks—as long as we integrated imaginary dogs into them! When we heard her put two words together for the first time (“Me drink”) we jumped at the chance to expand her repertoire (“me toy,” “me jump,” etc.) which would have been senseless to do during the many months when she never spoke more than one word at a time.

Planning and communication

From the start and continuing right through the year, regular communication with Tanika's parents, special education teacher, therapists—and communication within our own team—were crucial. At each point along the way, we planned what our focus would be and what our goals would be. At times the focus was mostly on self-care tasks and we didn't pressure Tanika on her language. At other points language was the main focus. Still other times, getting her to play more with other children was the main objective.

After a year learning all these new skills along with Tanika, I would have been really disappointed if the next year's group of four-year-olds included no children with developmental delays or disabilities. Fortunately, there were three sent my way that year—Devon, Nan, and Justin. I suppose I could tell you three more stories—now that I've become an “old pro”. But instead I think I'll get out of the way so that you can prepare to write your own stories about integrating children with special needs into community child care settings.

(This story was adapted from “Marisa Goes Mainstream” found in the *Monthly Resource*, Volume 3, Issue 3 by the Great Lakes Resource Access Project.)

OVERVIEW

This manual is organized into five sections: an introduction, a description of consultation procedures and suggestions for working with day care and special service providers, information on working with families, a series of workshop outlines on general topics related to working with children with special needs, and a group of nine “modules” based on specific categories of special needs.

The remainder of the INTRODUCTION explains the purpose, history, and philosophy behind the development of this manual. Suggestions for use of the manual by professionals and child care providers from a variety of different types of programs are offered. It is hoped that the manual will be useful to child care consultants, day care directors, recreation leaders, early intervention specialists, special education teachers and administrators, after-school program leaders, therapists, college instructors, children and family services staff, parents, and others.

The section on PROCEDURES describes the consultation approach to serving children with special needs in community child care settings. The role of a consultant is outlined and suggestions for adapting the role to settings where a separate staff person is not available to carry out this role are given. The unique and diverse characteristics of child care providers and the settings in which they work are discussed to focus users on the practical needs and problems that should be addressed. Working with multiple service providers is an important issue for a child receiving special educational or therapy services who is also in day care. Strategies for individualizing and adapting the child care setting to help a provider become an active participant and implementor of a child's Individual Education Plan or Individual Family Service Plan are outlined in this section. Specific strategies for serving children with special needs in community child care

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settings are listed.

The next section focuses on the special needs of working families with handicapped children. Some of the effects of having a handicapped child on the family system are described so that they can be explained to child care providers. Advice on helping families of children with special needs locate, choose, and use day care is offered. Also included is information on supporting families of children in day care. The special needs of siblings of handicapped children and how day care providers can support these children is an important part of this section.

Section IV includes information on developing and facilitating workshops to help child care providers learn to recognize and serve children with special needs. Suggested workshop outlines are provided.

The final section of this manual is a series of MODULES dealing with specific categories of handicapping conditions. Included in each module are:

- basic information that caregivers need to know and how it could be presented,*
- general suggestions for working with a child with this particular special need,*
- professionals who may be involved with the child,*
- how to recognize and refer a child that may have special needs in this area,*
- sample resource sheets for a child in each age group (0-2, pre-school, school-age) which gives a provider suggestions for addressing individual goals,*
- suggested workshop topics or speakers for this*

special needs area,

-supplemental handouts,

-and information on where to go for more information.

These modules are not meant to be a complete reference but offer general information that can be a springboard or starting point for further consultation. It should be emphasized that each child with special needs is an individual and that suggestions and adaptations for one child will not always work for another. Consultants should always make sure to check with the people working with a child to make sure suggestions offered are appropriate for a particular child.

PHILOSOPHY

The philosophy behind this manual is based on the idea that families and children with special needs deserve equal access to services that are available to children without special needs. If day care services are available to non-handicapped children, they should also be available to handicapped children. The reality of this situation is that, in general, there is a lack of quality child care services available to all children, not just handicapped children. The need is just stronger for children with special needs. The more disabled the child, the keener the need is felt.

This manual is also based on the belief that good quality child care can be good for children and poor quality child care is bad for children. If the child care being provided in a group of normally developing children is of poor quality, it is unlikely that good quality child care can be provided to delayed or disabled children in the same group. If a handicapped child is placed in a poor quality child care situation by a family, and

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alternate arrangements cannot or will not be made (for whatever reason), a consultant is best advised to help the provider to focus efforts into improving the quality of care to all children and not just the handicapped child. This manual uses the guidelines provided by the National Association for the Education of Young Children in their publication *Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age Eight* (Bredekamp, 1987) to define quality care.

HISTORY

Developmental Services Center's Children's Services in Champaign, Illinois is a private, non-profit agency serving families and children with special needs ages birth to three years. Services provided include a screening and referral program, a high risk intervention program, a home intervention program for children with identified developmental delays or disabilities, a respite program, New Friends and Kids on the Block special needs awareness programs, and the day care consultation program.

The day care consultation program at Children's Services was developed in response to needs identified by staff involved with families of children in day care. It was calculated that approximately 20% of the children in the home intervention program were also in day care. Although the staff frequently worked with children in their child care setting, these interactions or therapy sessions usually took place in areas apart from the caregivers and other children. Intervention staff came to realize that child care providers needed to know more about how to work with these children with special needs. They realized that a special educational program that only addressed the child in his family setting did not really meet the needs of the whole child. It did not deal with the functional needs of the child in

a setting in which he spent a large percentage of his time. Staff also recognized the fact that parents would feel more comfortable knowing that their child's individual program goals were being addressed in the child care setting and that there was coordination and communication between special service and child care providers.

The day care consultation program has been operating for over four years. Funding was originally provided by the Illinois Governor's Planning Council on Developmental Disabilities but is now being provided through a grant from the Illinois State Board of Education for the expansion of early intervention services under Part H of PL99-457. Funding for this manual is being provided by the Illinois Department of Children and Family Services. Funding is also being sought for the establishment of a model on-site integrated infant-toddler day care center, for expansion of the consultation program to serve older children, and to provide child care aides to community sites serving children with more severe disabilities.

USING THIS MANUAL

It is anticipated that a wide variety of people will be using this manual. It is recommended that the section on consultation procedures be read by anyone who wants to use this method to integrate children with special needs. This method of consultation will be most successful if the person fulfilling the role of day care consultant fully understands the needs of the child, the child care setting, the setting(s) in which special services are provided, and the needs of the family. When these needs are taken into consideration, successful integration is the likely result. Below are some suggestions on how people in different roles might best use the information provided in this manual:

Independent Consultant

An independent consultant without established or on-going contact with the child and family may best serve as an advisor, in-service training provider, or liaison between child care and special service providers. A consultant can provide training on general topics related to special needs (e.g. behavior management) or on specific topics as needed by a caregiver or caregivers (e.g. Down Syndrome). The independent consultant can also assist caregivers in integrating a specific child. The consultant can function in a variety of ways such as helping the caregiver make contact with special service providers, serving as a liaison between the child care setting and the special education setting, or modeling specific techniques or strategies. It is important to remember that a consultant must always work with written approval and appropriate releases of information from parents. Frequent contact with parents is also very important.

Day Care Center Director

Administrative support is extremely important for successful integration. A director should model a positive attitude toward children with special needs. She could use this manual as a guide for developing a staff training program. This staff training program could be a precursor to integration, or a means to better serving children with special needs who are currently enrolled in a center. A director could function in much the same way as a consultant. Making initial contacts with special service providers may be easier for directors than child care staff. Directors should allow work time for communication with special service providers. The efforts of staff working with special needs children should receive recognition and positive encouragement. Cooperative problem-solving techniques can be used when caregivers experience difficulties. It is the responsibility of the center director to maintain required written information on the children in her center who are receiving

special educational services. This written information includes:

- evidence that resource personnel with appropriate expertise have been consulted and their recommendations considered in planning program activities for children identified as having special needs.*
- releases of information to communicate with each special service provider (e.g. teacher,, pediatrician, audiologist). Sample forms are included in the section on "Consultation Procedures".*
- school records such as IEP/IFSP's and evaluation reports.*

Child Care Provider

A child care provider can use the integration strategies discussed in the section on PROCEDURES. The provider can use the manual to become familiar with services to children with special needs. Providers are especially encouraged to read and use the information in the section on FAMILIES. A provider should always consult with special service providers and parents about special techniques (egs. positioning and handling) that should be used with a child. The information in the SPECIAL NEEDS MODULES can be very helpful to a provider. It must be carefully noted, however, that this material is very general and may not be appropriate for a specific child. Parents and specialists working with a child should always be consulted for specific suggestions on the best ways to meet his needs.

After-School or Recreation Staff

Staff should be informed about the IEP of a child in their care. There should be many informal learning opportunities in this setting. After-school staff should communicate periodically with a child's special education teacher. Staff

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should share successes or difficulties the child experiences in the integrated setting. After-school staff can obtain information on setting up training from the manual as well as learn strategies for integrating children with special needs.

Early Intervention Staff

There are often people in early intervention programs who have had experience in day care. A child development specialist with this background could be the case manager for a child who is in day care. Consultation and coordination with child care providers should include as part of the child's Individual Family Service Plan (IFSP). Staff can alternate therapy visits between the family and the day care provider so that both are aware of strategies and suggestions for meeting program goals. Early intervention staff can also provide in-service training in the community, thus making child care providers aware of their services and support and assisting in child find efforts. The section on workshops could be helpful in this.

Special Education Teacher

The special education teacher should be aware of what the child is doing in the hours that he is not at school. If the teacher knows that the child is in day care, she should obtain permission from the child's parent(s) to talk with and share information with the child care provider. Child care providers are required to cooperate in implementing the child's program as developed by special service providers. Consultation with child care providers can be included as part of the child's Individual Education Plan (IEP). Child care providers are often afraid to bother teachers, so it is good if the teacher is able to make the initial contact and break the ice. Teachers should make sure that the child care provider has a copy of the child's IEP, understand what it means, and has information on how goals and objectives can be addressed in the integrated setting. Special education personnel should avoid jargon when-

ever possible.

Parent

A parent could also fulfill the role of consultant. Parents are encouraged to read the information on how parents can support day care which is in the section on FAMILIES OF CHILDREN WITH SPECIAL NEEDS. The information on strategies will also be helpful to know and share with caregivers. Parents are encouraged to share their knowledge and resources about their child and his disability. They should share as much information as possible with caregivers who may or may not feel comfortable asking for information and help. Parents can also request that integration be encouraged via consultation with caregivers as part of their child's Individual Education Plan or Individual Family Service Plan.

DCFS Staff

It will be helpful for DCFS staff to know some integration strategies that they can share with providers. DCFS staff should encourage providers to consider serving/caring for children with special needs, and let them know how they can get more training in this area. Services to children with special needs should be addressed in licensing visits. Records should be checked to make sure services are being coordinated. If they are not, staff should share strategies on how best to do this.

Resource and Referral Staff

Resource and referral staff can make information available to parents about day care providers who have experience or training for serving children with special needs. They can address the need for providers to serve children with special needs in recruiting efforts. The section on "Developing and Facilitating Workshops" will be helpful to resource and referral staff setting up training in their area.

Section I - Introduction

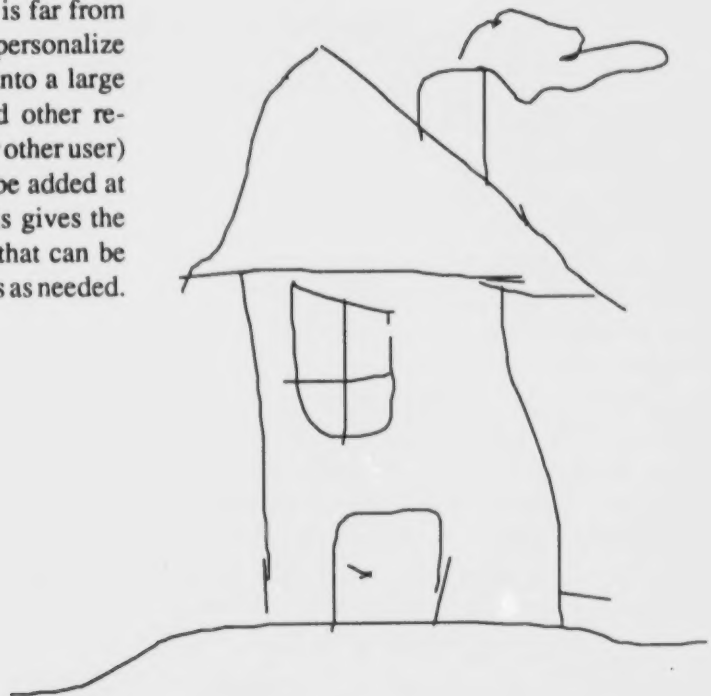
Specialists (e.g. occupational therapist, speech therapist, teacher of the hearing impaired)

A specialist can use this manual to develop awareness of the needs of children and caregivers in day care settings. It is hoped that this manual will help the specialist to provide more usable and effective suggestions and in-service training when called upon to do so.

Instructor (community college instructor or other trainer)

An instructor could use this manual to develop a course of pre-service or inservice training on "children with special needs". The manual does not discuss the development of individualized education or family service plans because it is believed that these are the primary responsibility of special service providers. This manual will be most useful in helping child care providers to learn basic information about families and children with special needs, and about serving children with special needs in integrated settings.

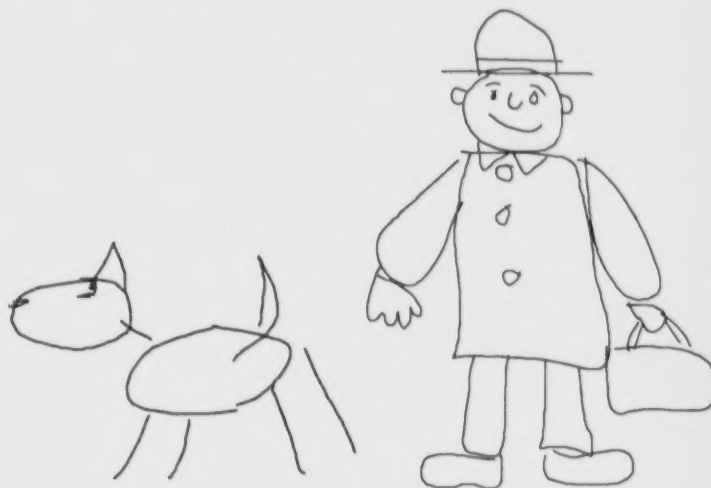
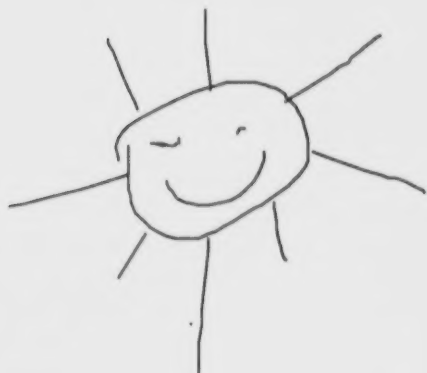
Information included in this manual is far from complete. Users are encouraged to personalize the manual by putting the material into a large loose leaf notebook. Handouts and other resource material that the consultant (or other user) has developed or found helpful can be added at the end of appropriate sections. This gives the consultant a "bank" of information that can be easily referred to or shared with others as needed.



Section II - *Procedures*

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Section II - Procedures

INTRODUCTION

For many years, research has been indicating that the development of children with handicaps or developmental delays is enhanced when they are in environments with children whose development is within normal limits. We learned long ago that "separate is not equal". This section of the manual is designed to help professionals in different settings establish procedures and interactions which will facilitate the integration of children with special needs into child care settings with children who are developing normally. This model is built around the understanding that child care settings can be integrated successfully if staff in those settings are supported and offered some assistance and training. This support and training can be offered or arranged through a "consultant" who provides information, guidance, and assistance with individual children and their integration into the setting. The role of "consultant" can be assumed by any of several professionals who may be involved with a particular child or with many children who need integrated child care placement.

THE CONSULTATION MODEL

The consultation model includes sharing information and resources, and facilitating the development of solutions to client-identified problems or plans to meet client-identified needs.

This manual addresses four types of consultation. The type of consultation depends on whether you are consulting with a group or with an individual, and whether the information provided is specific to one child or to children in general. These four types of consultation can be represented by the following grid:

	INDIVIDUAL	GROUP
CHILD SPECIFIC	1	2
GENERAL	3	4

The first type of consultation (1) is a child specific consultation with one or two day care providers. This could involve developing strategies for implementing a child's Individual Education Plan (I.E.P.) or Individual Family Service Plan (I.F.S.P.) into the daily activities of the child care setting. It may involve the development of solutions to problems a child is having in the day care setting. For example, a consultant could provide information to a day care provider on specific signs that a child with a hearing impairment knows now and what signs she is learning.

The second type of consultation (2) is a child specific consultation with a group of child care providers. In this type, the consultant might work with all the staff in one day care setting to help develop or implement strategies to meet the needs of one child. For example, a consultant may facilitate a meeting of all the service providers (both day care and special services) to focus on the feeding problems of one child.

The third type of consultation (3) involves consulting with one or two child care providers about a general topic. An example of this is an informational session for a family day care provider on how to arrange the day care home to avoid behavior problems.

The fourth type of consultation (4) involves

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working with a group to provide information on general topics. This type of consultation is usually done in a workshop or in-service training format. An example of this is providing or arranging for a workshop on language development to infant and toddler caregivers in the community.

This manual provides information that a consultant can use for all of these types of consulting. Child specific consultation is addressed primarily in this section and in the SPECIAL NEEDS MODULES. Information on general topics is addressed both in the SPECIAL NEEDS MODULES and in the WORKSHOP SERIES OUTLINES which are primarily geared toward groups of child care providers. Please see these sections for more information.

THE CONSULTATION PROCESS

The consultation process used here involves five steps. They are: *Assess, Plan, Implement, Evaluate, and Revise.*

This process can be used to work on a specific problem or problems or to develop a more comprehensive training or integration plan. Throughout this process, the caregiver(s) should be involved. The more caregivers are involved in the process of assessing and planning, the more likely it is that the plan will be implemented and that the consultation will meet their needs and those of the children. This is why the definition of consultation used here includes the terms "client-identified problems and needs".

Assess

In assessing problems and/or needs, three main categories should be considered: *the environment, the curriculum or program, and the people.*

environment- some things to look at in the envi-

ronment include materials and equipment available (both indoors and outdoors), room arrangement, safety hazards, noise level, lighting, temperature, cleanliness, surfaces (carpeting, tile, walls, playground surfaces, etc.), the amount of clutter, accessibility, general atmosphere (sterile or homelike), etc. *The Harms Early Childhood Environment Rating Scale* and *The Harms Family Day Care Rating Scale* (see references at the end of this section) can be very helpful for consultants and providers in assessing the environment.

curriculum/program- some things to look at in the curriculum or program include the daily schedule, routines, types of activities, how activities are done (one to one, large groups, small groups, etc.), the amount of time spent in child-directed versus teacher-directed activities, etc.

people- consider adults and children. Adults include caregivers, administrators, parents, therapists, and other people such as bus drivers and cooks that come in contact with children with special needs. Look at the education and experience of the adults. What training is needed to enable this person to meet a child's special needs? A TRAINING NEEDS ASSESSMENT is included at the end of this section of the manual. Consultants are encouraged to revise the contents to adapt to their own needs. Teacher attitude is regarded as the most important determinant of success in an integrated setting. Are all those involved committed to meeting the needs of ALL children? Included at the end of this section of the manual is an attitude assessment entitled DAY CARE INTEGRATION INVENTORY. Consider the ratio of adults to children. Will there be enough help to serve children with more extensive needs? How could more help be obtained? Consider the children. What is the group size? What kinds of abilities and disabilities are represented? Is this a same-age or a multi-age group? Carefully assess the needs of

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the child with special needs? What kinds of services is he receiving, and where and when is he receiving them? Are there any special handling procedures that are required? How about special feeding techniques? What are the interests and strengths of the child?

Plan

Planning can be done with an individual or with a team. Planning involves the development of a STRATEGY or strategies for solving a problem or meeting a need. Plans can be developed by a team to help a day care provider to meet the needs of a specific child. All children with special needs who are in early intervention or special education programs have an Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP). A consultant can help to plan ways that the day care provider can help to implement the IEP or IFSP. Examples of this type of plan are included in the SPECIAL NEEDS MODULES. A plan can be a single suggestion or it can be a more involved, long term plan. Training plans can be developed for individual caregivers based on their own identified needs. An example of this, called a TEACHER IN-SERVICE PLAN (TIP), is included at the end of this section. A similar plan can be developed for an entire day care center staff prior to the integration of children with special needs. Regardless of what the plan is, it should be agreed upon by all those involved in its development and implementation. When developing a plan to meet the needs of a specific child, the consultant (or person assuming that role) should ALWAYS check with therapists to make sure that the plan is appropriate for the child.

Implement

This step involves the implementation of the plan. In this step, the caregiver tries out suggestions or activities or takes part in training activities. Implementation on the part of the consultant might involve the provision of training materials,

modeling a technique, doing a workshop, or substituting for the caregiver so she can attend a staffing.

Evaluate

This step is where the question "How did it go?" is answered. Other questions to consider include "What went right?", "What went wrong?", "How did the child respond?", "Did the training meet your needs?", "What else is needed?", etc.

Revise

In this step, the original plan is revised as needed based on the evaluation step. The revised plan is then implemented and re-evaluated. If the original plan is implemented satisfactorily, the process is complete.

COMMUNICATION SKILLS

When working with child care providers, a consultant must learn to be a good communicator. Developing good listening skills is an important step in becoming a good consultant. A workshop titled "Communication Skills" which is included in the WORKSHOP SERIES OUTLINES in this manual contains information on this topic. Two skills discussed in this workshop are especially important for consultants. These are *Active Listening* and *Asking Clarifying Questions*.

Active Listening

Active listening involves paraphrasing what the other person is saying to be sure you are interpreting correctly. For example, "You think that Amber is having trouble here because she is not getting enough attention at home, is that right?" It also involves making eye contact with the other person, and making encouraging comments to get the other person to continue, such as "yes", "I see", etc.

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Asking Clarifying Questions

Asking clarifying questions encourages the other person to provide more information and helps the listener to make sure she is understanding what the speaker is saying. Open questions as opposed to closed questions are good examples of the types of questions to ask. Closed questions encourage simple yes or no answers. Many clarifying questions begin with "who", "what", "when", "where", "how", and "why". Examples include "Tell me more about that", "What happens when you put the spoon into Mario's mouth?", and "Why do you think that happens?".

When working with caregivers and others without special education training, it is important to AVOID PROFESSIONAL JARGON. Professional jargon includes abbreviations, such as "IEP", "OT", "DSCC", etc., titles of professionals, such as "occupational therapist" or "otolaryngologist", and other general terms, such as "motor planning" and "visual perception".

One final point in consulting with caregivers is to AVOID POUNCING. Pouncing is giving more information than is needed or wanted. It is bombarding the caregiver with so many suggestions or recommendations that she is overwhelmed. We all learn best when information is provided in small doses. It is best to provide a short article or handout on a topic rather than a whole book. It is also best to suggest one or two activities or adaptations at first rather than a whole list. The caregiver is then free to ask for more as she desires. It is always helpful to point out the things that the caregiver is already doing that are helping to meet the needs of the child.

RECRUITING CAREGIVERS FOR CHILDREN WITH SPECIAL NEEDS

Developing a network of caregivers who can be relied upon to work with children with special

needs requires some effort. Centers or homes can be recruited through word of mouth, or through personal contacts with directors or home providers. Lists of licensed day care homes and centers can be obtained from the Department of Children and Family Services or the area Resource and Referral Service. Homes and centers are surveyed to determine experience and/or skills for serving children with special needs. Some early intervention and public school special education programs may know of caregivers who have served their children. Parents of children with special needs are another source for locating caregivers. Parents may know of caregivers who have taken children with special needs, or they themselves may be interested in becoming child care providers. Agencies and schools serving children with special needs could provide workshops or in-service training for providers in community child care settings. Providers can also be recruited at these and other conferences or meetings of child care providers. One early intervention agency provides a liaison to the local day care directors' group. If an agency or school decides to sponsor a network of child care providers, it is important that they provide on-site support to these providers.

SUPPORTING CHILD CARE PROVIDERS

Support can be provided to child care providers in a variety of ways. It is helpful to think back to the four types of consultation described earlier in this section. The process of consultation can be used to provide support in many forms:

-The least intrusive, and the kind of support most likely to be given initially, is to observe (ASSESS) in the classroom and develop suggestions and recommendations (PLAN). This allows the provider to remain in control, and allows the consultant a chance to get a feel for the program and the child's place in it. It is

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helpful to set some specific objectives for each observation. This can be done by asking the provider if there are some particular aspects of the program she would like the consultant to observe, or if she would like suggestions regarding particular activities or needs of the child. Again, this gives the provider control of the situation, and tailors the interaction to her needs.

-The consultant may lead group activities, to model some ways of integrating the child with special needs into those activities, or to give the provider a chance to observe the situation in order to develop some improvements on her own. In this situation, the consultant may model communications with all children, or demonstrate teaching methods and activities.

-The consultant may serve as a substitute for a time in the classroom so that the provider can participate in therapy sessions, or observe the group as a whole.

-The consultant may record activities on video tape for later joint viewing with the provider. If the child is receiving speech therapy, occupational therapy, or physical therapy the consultant may make videotapes of these sessions to view with the provider. These would convey valuable information regarding the child's therapy program and possible ways of integrating therapy goals into the child care program. Videotapes of the child in the day care setting could also provide valuable information to the child's therapists and could be helpful in establishing therapy goals or adapting activities for use in the community child care setting.

-Some regular time should be set aside for the consultant and provider to meet. There may be a regular nap time or free play time when the consultant and provider can get together to discuss issues and brainstorm improvements. Don't

forget that the telephone works well in a pinch.

-It is sometimes useful to bring together some providers who are integrating children with special needs into their programs. This can be done in small groups, during an in-service time or in an evening meeting. It is helpful to run this group as an open ended meeting rather than an instructional gathering. Some questions should be prepared ahead of time to stimulate discussion, but providers appreciate the opportunity to share their experiences and ask questions of one another.

In general, a consultant should provide a supportive presence for the child care provider. It facilitates the process of integration if the provider is given helpful information and suggestions, rather than receiving criticism or curriculum or policies.

ATTITUDES

Attitude is an important factor in the success or failure of any integration effort. The consultant plays a vital role in breaking down negative attitudes and building up positive attitudes toward integration. One way in which a consultant can help caregivers is to bring negative attitudes or expectations out into the open. Negative attitudes are usually caused by feelings that they are not capable of meeting the special needs of a particular child. They may feel that they do not have adequate knowledge of a particular handicapping condition and do not have adequate resources or support. They worry that a child with special needs may take up too much of their already stretched time and take time away from the other children in the group. It is important for a consultant to provide a greater amount of on-site support when a child is first enrolled in the center or day care home if possible. This could mean daily support depending on the extent of

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the child's needs and the capability and confidence of the caregiver(s). It may mean advance preparation and training for the provider.

Some providers are embarrassed about their own deep feelings of pity or sorrow for the child with special needs. They should be reassured that these feelings are normal and that expressing them appropriately is important. They must also learn how to care for the child without letting these feelings get in the way of the child's normal adaptation to the group setting or to the quality of care the child should receive.

In most cases where attitudes are less than positive in the beginning, this can be quickly turned around as the provider gets to know the child with special needs and develops confidence in her own abilities. Providers soon learn to enjoy the challenge and reward of having a "special child" in the group. Frequently, they are pleasantly surprised. Center providers have even requested that they change classes in order to "follow" the child with special needs. Some may express interest in obtaining further professional training that would enable them to work with children with special needs on a full time basis.

PLACING CHILDREN WITH SPECIAL NEEDS IN GROUPS

A common concern in the area of integration is deciding in which age group to place a child. There are two major questions to ask in relation to grouping. The first question is "Which class should a child be placed in initially?" The second question is "When should the child be moved to the next oldest age group?" There are many factors to consider in answering these questions. The following are some of the factors to consider regarding the grouping of children:

Single-age Groups

chronological age of the child- a general guideline is that the child should not be younger than the average age of children without special needs in the class. In other words, the child with special needs should (preferably) not be also one of the youngest children in the class. It is perhaps better if the child with special needs is one of the oldest children.

developmental age- the child should generally be functioning at least on the level of the youngest child without special needs, although this is not always possible in the youngest (infant) age group. In this way, the child has both peers and models in the same classroom.

type of special need(s)- integrating has been done successfully with many types of special needs. This will be somewhat different for a child with a physical handicap and a child with a speech/language problem.

severity of the special need- usually, the more severe the need the more time a caregiver will need to deal with the child. The classroom with a lower staff:child ratio would probably be more appropriate. (Usually, a younger group will have a lower ratio).

mobility- it can be difficult and possibly dangerous to have a crawling child in a classroom with all walking children, especially if the children are not proficient enough to be able to avoid obstacles. It is also possible that the non-walker who needs a little extra motivation to get up on both feet can be stimulated to try a little harder when "all the other kids are doing it". For the child who is not really ready or able to walk, this could be a source of frustration.

size of group and child:staff ratio- many centers feel that lower child:staff ratios are required if a

child with special needs is enrolled in the class. Lower ratios are not required unless children with special needs are being served as a group (ie. an entire class of children with special needs). Center caregivers should, however, consider whether or not they can meet the needs of the child with the current ratio. Family day care providers are required to count the child with special needs at his developmental rather than chronological age.

number of other children with special needs in the class- if too many children with extensive needs are in a class, the provider may not be able to handle it without help. She may "burn out" quickly and/or the children may not get the attention they need.

competence of providers- if a provider has a particular skill that is especially advantageous to a child with a special need (e.g. a teacher who knows sign language would be good for a deaf child), it is natural to try to put the child with that teacher for as much time as possible, and perhaps allow that teacher to "follow" the child to the next age group in this is practical or possible. A new teacher should be prepared in advance for the child with special needs whenever possible. Preparation leads to more positive experiences for all the children.

special child:child attachments- it is always advantageous to move a child to the next age group "with a friend". This will make the transition easier for all.

attitudes of children- young children can be prepared for the child with special needs by the use of peer dolls with special needs, good quality story books, etc. This is usually not a problem in the 0-3 population.

(#1-4 from Guralnick, 1984)

Multi-age Groups

Multi-age groups are most often seen in family day care homes and after-school programs. Family day care homes often serve children from six weeks to twelve years. After-school programs often serve children from two or more grade levels in one group. Multi-age groupings can be the best type of group choice for many children with special needs. In a multi-age group, the child can have both peers and models. Differences in ability are not as noticeable if a wider range of ability levels is represented in the group. It is important to keep in mind that some children with special needs are not only delayed, but different in other ways. They may have different sensory abilities or have behaviors which are unusual. Children in multi-age groups should be prepared for children who are different just as you would prepare children in a single-age group.

STAFF-PARENT CONFLICTS

Disagreements between parents and staff are not unusual in child care situations. They may arise more often with children who have special needs, because parents may be more involved with their child's education and because the child may be less able to make independent adaptations to the child care situation. The consultant may be called upon to resolve or negotiate these conflicts. As with many situations of conflict, the best resolution is preventative.

Conflicts tend to arise regarding the right placement for the child, or regarding the level of supervision being given the child. Both of these issues should be negotiated and well agreed to prior to placing the child in day care. The information in this manual regarding group placement should be helpful in determining the right placement for a young child. The level of supervision available and appropriate for a child is, of

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course, dependent on the group in which the child is placed, and should be a part of the decision regarding grouping. If a disagreement develops, the best strategy is to call a meeting and negotiate the issue. The consultant's role in such a meeting is to act as a facilitator. It is important to explore the parents' concerns such as, "why is it important for the child to have a certain level of supervision?". It is also important to recognize that the disagreement may not be resolved, and the parent may have to face the option of removing the child. In fact, it is not unusual for a parent to have to try several child care centers or homes before an appropriate setting is found. Parents should be reassured that this is not unusual, and not an indication that their child is unwanted. It may just take time to find the right match between child and provider.

THE REGULAR VS. SPECIAL EDUCATION DILEMMA

A potential source of conflict and confusion for parents and child care providers is the difference in approach to learning between special educators and regular educators or child care providers. The developmental approach of regular educators may seem unproductive and unfocused to someone who is used to the functional and individualized approach of special education. Conversely, the methods of special education may seem unnecessarily restrictive and specific to someone used to working in a regular education setting. A special educator serving as a consultant must keep in mind these differences.

Some of the most important differences are child:staff ratio, group size, educational level and/or course content of providers, length of day, and planning time available. Day care providers work in settings where the group size and child to staff ratio are often twice as high as in a special education setting. Although some child care

providers may have bachelor's or associate's degrees in child development or early childhood education, most have much less. The minimum standards for a child care worker are six hours of college credit in child development or early education plus two years of college credits OR one year of experience OR Child Development Associate (CDA) credential. Family day care home providers are not required to have any college credit. Most child care workers have had no training or experience in working with children with special needs. Most child care providers spend at least eight hours a day working with children. Most family day care providers spend even more. Because of low wages, many child care providers also have second jobs to be able to support themselves. Day care providers often have very little, if any, planning time. They often use the children's nap time to prepare for the next day. Providers working with infants and toddlers may not have a regular nap time they can use for planning and for meetings. After-school providers are even less likely to have planning and meeting time.

Some suggestions and precautions for consultants:

-Do not suggest activities that are only appropriate for the child with special needs. Remember that a day care provider will not have much one to one time to spend with a child.

-Make sure that special service providers are aware of the skills needed by the child to function in the child care setting. Teaching and learning these skills can become part of the child's individual program plan.

-Help the provider to find and/or make materials that would make working with the child with special needs easier. Adaptive seating is one kind of material that may be required.

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-Don't suggest activities or adaptations that are against the basic philosophy of the child care provider if possible.

-Use scheduled naptimes for in-service or problem solving meetings. If there is not a regularly scheduled nap time, maybe there is a slow time when the director or other staff member could fill in for a while. Family day care providers may want to talk over the phone in the evening when the children are not there.

-Keep in mind the daily schedule and activities of the child care setting. Suggest activities and adaptations that fit in with what the provider is already doing. Providers are always looking for new ideas.

-Do not provide articles and other reading materials that are too technical and not geared to the functional needs of the child or caregiver.

MULTIPLE SERVICE PROVIDERS

Most children with diagnosed special needs are involved with a number of different therapists and specialists. These may include a speech and language therapist, child development specialist, special educator, an occupational therapist and/or physical therapist, an audiologist, and numerous medical specialists such as a pediatric neurologist or otolaryngologist. Before a child care provider can communicate with a child's service providers, she must know who is involved and she must have written permission from the parent(s) to contact them. Usually the parent will know what services the child is receiving or at least who the primary service provider is (e.g. the public school). The provider should have the parent sign a "release of information" so that she can talk to these professionals. Some sample forms are included at the end of this section.

Most child care providers are not familiar with the functions of the many professionals that may be involved with the child. A one year old does not need an occupation, so why does he need an occupational therapist? Each of these different professions also has his own jargon or shorthand which can make communication confusing. Most child care providers are not familiar with terms like "bi-manual coordination", "sensory integration", and "hypotonia" as well as the numerous abbreviations used in special education. We can make this part of the special education mystique less mysterious by providing glossaries of frequently used terms and abbreviations (an example is included at the end of this manual), by referring providers to a medical dictionary, and/or clarifying terms ourselves as consultants. It is helpful to write clarification of terms directly on written reports when sharing them with providers. Special service providers should be encouraged to include explanations of terms in their written reports in order to make them readable by both parents and caregivers. The contents of written reports, recommendations or Individual Education Plans should be discussed at formal consultation meetings to ensure that they are understood.

Whenever possible, child care providers should have the opportunity to personally meet with other service providers such as physical, occupational, or speech therapists. This is usually done best by having the therapist come to the center or home for a therapy session. This way, the provider can get to know the person, observe how the therapist works with the child, and ask any questions she may have. The therapist can make any suggestions for adapting the child care environment or add other "helpful hints" on implementing her practical curriculum goals for the child. It can be very helpful for the therapist to see the child in his/her child care setting so that she can develop programming which will help the child to function as normally as possible in his own

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world. It is useful to see how the child with special needs adapts and interacts with normally developing children.

As previously mentioned, videotaping is an excellent tool for communication between team members. It is usually not possible for a therapist to do therapy in the child care setting as often as needed. By showing videotapes of therapy sessions, the provider can learn what a therapist is really doing with a child. Videotapes can be viewed at the provider's home (if confidentiality is strictly maintained) or the consultant could bring the tape and video equipment to the child care setting at naptime. The latter usually works well because the provider and consultant can view and discuss the therapy session as it happens on the screen.

The child care provider should be encouraged to attend any multi-disciplinary staffings that are held to discuss a child in her care. The provider may be implementing parts of the child's therapy, and so should function as an important team member if possible. Getting release time to attend a staffing is usually difficult for a provider. If a substitute cannot be obtained by the provider, a day care consultant could be the substitute in some cases if this meets with the approval of the provider or her employer. Staffings can also be held at the child care setting if this is convenient for team members and the provider.

STRATEGIES FOR INTEGRATION

For many teachers, child care providers, or group leaders the idea of integrating children with special needs seems like the right thing to do. They may agree that it should be done, and that they would like to support it, but at some point, they will ask "How do I do it? When that child is in my group, what do I do?" When this question arises, the following ideas and guidelines will be helpful.

There are two main goals of integration for children with special needs. These are 1) social integration, and 2) skill enhancement. Skill enhancement will be guided by the child's IEP or IFSP, and is facilitated by direct instruction and specific adaptations of materials and activities. Social integration will be facilitated by specific strategies which are designed to encourage positive social interactions. Teachers should be reminded that these are not exclusive categories. Much direct instruction can be done in situations which will require social interactions. It is also important to understand that environments which focus on cooperative learning and play for everyone are best able to support positive social outcomes and successfully accommodate children who exhibit a wide range of skills and abilities.

Guidelines

integrate the child, don't change the program-

Many child care programs are developmentally based, and focus on exploration, open-ended materials, and choice of activities. Children with special needs may require more structured learning activities than many child care providers are accustomed to. This does not mean that the program has to be restructured to provide the same activities for everyone, or that the child who is different has to be doing things that are special and different. Integration assumes that all children benefit from an environment that is challenging and responsive, and that all children benefit from an environment full of interesting people, events, and objects.

gather as much information as you can-

Child care providers should try to find out as much as they can about the child, about the disability, and about what happens in other programs the child may attend. Talk to other teachers, therapists, and the child's parents. Observe the child as much as possible. It is important to ask the same questions you would ask about any

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child. What do they like to do? What do they do best? It is also important to ask these things of the child if possible. Providers must also remember that information should be gathered, and anything which seems to be heading toward gossip or speculation should be avoided.

structure learning into program routines-

A predictable and organized environment is important for any child, but more important for many children with special needs. It is important to familiarize the child with routines, but it is also important not to feel that routines have to be compromised for the child with special needs. Any rules that apply to children in the group should also apply to the child with special needs. For example, everyone needs to help clean-up, though what they do may vary.

prepare the children in the group for a "different" child-

Even very young children need help in understanding and accepting someone who is different. It helps to prepare children before a child with a special need joins their group, or to give them some help in understanding a "different" child who unexpectedly joins their group. There are many books available from local public libraries which deal with the feelings and experiences of children who are different and their families. "Kids on the Block" is a commercially available program which presents issues of disability to elementary age children through the use of puppets. "New Friends" is a program available through the Chapel Hill Training Outreach Project which does the same for preschool age children through use of life-size dolls. These are both programs which require some time and effort to develop, but if used extensively, they can have a significant impact on the attitudes of children in a community.

Simulating handicaps is a strategy which has proven useful to many programs in helping chil-

dren feel what it is like to have a particular special need. Using blindfolds or earplugs, tying an arm behind the back or tying two legs together, or talking with a mouthful of marshmallows can give children a sense of barriers that other children may have to deal with.

adapt materials and activities-

Every child will need to have activities and materials adapted to fit their needs. Physical adaptations of equipment or furnishings should be supervised by a physical or occupational therapist. It is always advisable to use other specialists as resources when faced with a child who presents challenges in terms of planning activities for individual groups. Adaptations are always specific to each child, but there are some general suggestions which may be helpful. The modules in this manual each contain SUGGESTIONS FOR INTEGRATING CHILDREN WITH For example, for a child with a hearing impairment, it is suggested that the provider put picture labels on objects around the room, and that activities using visual cues and providing lots of tactile experiences would be helpful to the child. One caution is appropriate here. Though some activities may need to be made simpler, it is important to keep the content of activities appropriate to the child's age. For example, though school age children may need simpler puzzles than same age peers, the puzzles should not be of objects used by preschoolers.

structure social interaction-

There are several strategies for facilitating social interactions between children who have special needs and their peers. As previously mentioned, the easiest way to encourage social integration is to develop an atmosphere of mutual respect and cooperative learning in the group. Peer "buddies" or tutors, and peer imitation or modeling are two strategies which seem easy for many providers to use in group settings.

Frequently, a buddy for an activity, or a tutor for

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a learning experience can be assigned to the child who needs special help. This should be made into a special and desirable assignment, and sometimes helps if it is offered as a reward. The tutor should feel increased status and get more adult attention. This kind of assignment affords the tutor the chance to practice helping skills and adult role-taking. Usually a same-sex, older tutor works best. Tutoring sessions should be short at first, and increase in length as the tutor's skills increase. Though this situation frequently works well, it must be monitored to avoid chaos and exploitation.

Peer modeling takes place incidentally when children are together in groups. Sometimes including a child with special needs in a small group activity of three or four children will facilitate the modeling process. Modeling can be used for general skill development (point out how someone solved a particular problem) or for a specific skill, such as expressive language. Direct instruction techniques are appropriate for modeling behaviors or skills. For example, it helps when the teacher says something like "Johnny just said, now you say"

Child care providers and teachers must remember that children who are slow learners may need to have activities or behaviors modeled repeatedly before they reproduce the behavior. Patience and persistence are crucial. If the skill is learned in one setting or activity, it may also have to be modeled or taught in another setting. The child may not transfer the behavior from one setting to another.

To summarize, integration does not just happen by placing different kinds of children in the same room. Specific strategies and adaptations need to be put in place to encourage the kinds of positive learning and social experiences we hope are the result of being and learning together.

RESOURCES

Anti-Bias Curriculum, Tools for Empowering Young Children

by Louise Derman-Sparks and the A.B.C. Task Force (1989)

Washington, DC: National Association for the Education of Young Children

Children with Special Needs in Family Day Care Homes, A Handbook for Family Day Care Providers

by Beatrice de la Brosse (1987)

El Centro de Rosemount
Washington, DC

Council for Exceptional Children (CEC)

1920 Association Drive
Reston, VA 22091-1589
703-620-3660

Direction Service of Illinois

730 E. Vine, Room 107
Springfield, IL 62703
217/523-1232

ERIC Clearinghouse on Exceptional Children

1411 South Jefferson Highway, Suite 900
Arlington, VA 22202

Exceptional Parent Magazine

Psy-Ed Corporation
1170 Commonwealth Ave.
Boston, MA 02134

Great Lakes Resource Access Project

Department of Special Education
University of Illinois at Urbana-Champaign
240 Colonel Wolfe School
403 East Healey Street
Champaign, IL 61820

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Illinois Birth to Three Clearinghouse
830 South Spring Street
Springfield, IL 62704
217/785-1364
FAX 217/524-5339

Including All of Us: An Early Childhood Curriculum About Disability
by Foschl, M., Colon, L., Rubin, E., and Sprung, B. (1985).
Educational Equity Concepts, Inc.

Kids on the Block
822 North Fairfax St.
Alexandria, VA 22314
800/368-5437
or
The Kids' Project
New York State Office of Mental Retardation
and Developmental Disabilities
44 Holland Ave.
Albany, NY 12229
518/473-3500

Mainstreaming Ideas for Teaching Young Children
by J. Souweine, S. Crimmins, & C. Mazel (1981)
Washington, DC: National Association for the
Education of Young Children

National Early Childhood Technical Assistance
System (NEC*TAS)
CB#8040
500 NCBN Plaza
The University of North Carolina
Chapel Hill, NC 27599
919/962-2001

National Information Center For Handicapped
Children and Youth (NICHCY)
Box 1492
Washington, DC 20013
703/893-6061

National Lekotek Center
2100 Ridge Avenue
Evanston, IL 60201
708/328-0001
(see listing of all Illinois Lekotek sites)

National Organization on Disability
1-800-248-ABLE

National Rehabilitation Information Center
(NARIC)
8455 Colesville Road, #935
Silver Spring, MD 20910
1-800-34NARIC

New Friends: Mainstreaming Activities to Help
Young Children Understand and Accept
Individual Differences
Chapel Hill Training-Outreach Project (1983).
Lincoln Center, Merritt Mill Road, Chapel Hill,
North Carolina, 27514. 919/967-8295

Project Headstart Mainstreaming Preschoolers
Series (8 books):
Children with Emotional Disturbance (DHEW
Publication No. OHDS 80-31115)
Children with Learning Disabilities (OHDS 78-
31117)
Children with Mental Retardation (OHDS 78-
31110)
*Children with Speech and Language Impair-
ments* (OHDS 78-31113)
Children with Health Impairments (OHDS 80-
31111)
Children with Hearing Impairment (OHDS 78-
31116)
Children with Visual Handicaps (OHDS 79-
31112)
Children with Orthopedic Handicaps (OHDS
80-31114)
U.S. Government Printing Office
Washington, D.C. 20402

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Project Neighborcare, Training Manual for Family Day Care

Pierce Hall
Purdue University
West Lafayette, IN 47907

Project RHISE/Outreach
Children's Development Center
650 North Main Street
Rockford, IL 61103

Resources for Teaching Young Children with Special Needs

by Penny Low Deiner (1983)
New York: Harcourt, Brace, and Jovanovich

School Age Children with Special Needs: What Do They Do When School Is Out

Dale Borman Fink (1988)
Boston, MA: Exceptional Parent Press

Special Friends Program: A Trainer's Manual for Integrated Settings

University of Hawaii
Honolulu, Hawaii

Structured Experiences for Integration of Handicapped Children

by K. Anderson & A. Milliren (1983)
Rockville, MD: Aspen Publications

The Early Childhood Environment Rating Scale and The Family Day Care Rating Scale

by T. Harms and R. Clifford
Columbia: Teachers College Press
(available from Kaplan and other materials catalogs)

We're In This Together

Resource Manual for Integrating Handicapped Children into Day Care and Preschool Programs

Iowa Department of Education
Bureau of Special Education

by Linda Lewis, Training Coordinator
Early Childhood Special Education
Des Moines Independent Schools
Smouse School
2820 Center
Des Moines, Iowa 50312

REFERENCES

Berryman, J.D. & Neal, W.R. (1980). The Cross Validation of the Attitudes Toward Mainstreaming Scale (ATMS). *Educational and Psychological Measurement*, 40, 469-474.

Bredenkamp, S. ed. (1986). *Developmentally Appropriate Practice*. National Association for the Education of Young Children.

Canadian Association for the Mentally Retarded (1978). *Children with Special Needs in Day Care, A Guide for Integration*.

Cook, R.E., & Armbruster, V.B. (1983). *Adapting Early Childhood Curricula*. St. Louis, MO: C.V. Mosby Company.

Evans, J. (1979). *Handicapped Children in Day Care*. Texas Child Care Quarterly, September, 1979.

Gil, L.L. (1984) *Integrating Normally Developing and Handicapped Infants and Toddlers inot a Child Care Program*. Seattle, WA: Northwest Center Infant and Toddler Development Program, 1600 West Armory Way, Seattle, WA 98119, 206/285-9140 (available from ERIC).

Guralnick, M.J., ed. (1984). *Early Intervention and the Integration of Handicapped and Nonhandicapped Children*. Baltimore, MD: University Park Press.

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Heron, T. & Harris, K. (1982). *The Educational Consultant: Helping Professionals, Parents, and Mainstreamed Students*. Allyn and Bacon, Inc.

Idol-Maestas, L. (1983) *Special Educator's Consultation Handbook*. Rockville, MD: Aspen Publications.

King, D. (1988). How to Work with a Consultant When Mainstreaming Special-Needs Children in Centers. *Child Care Center*. January, 1988, 41-42.

Meisels, S.J. (1977). First Steps in Mainstreaming: Some Questions and Answers. *Young Children*, 33, 4-13.

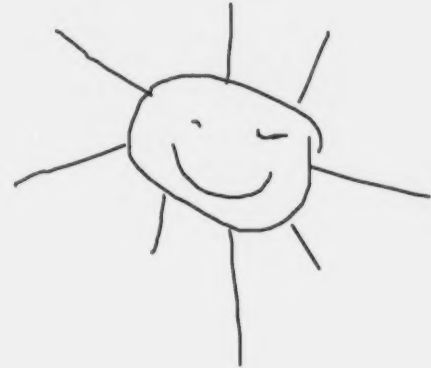
Ostroff, E. & McGuinness, K. (1988). Adaptive Environments: Classrooms for All Kinds of Children. *Beginnings*, summer, 1988, 118-120.

Saracho, O.N. & Spodek, B. (1987,88). Play for Young Handicapped Children in an Integrated Setting, Parts 1 & 2. *Day Care and Early Education*. Fall, 1987 & Spring, 1988:

Shotel, J., Iano, R., and McGettigan, J. (1972). Teacher Attitudes Associated with the Integration of Handicapped Children. *Exceptional Children*, 38, 677-683.

Vincent, L., Broion, L., and Getz-Sheftel, M. (1981). Integrating Handicapped and Typical Children during the Preschool Years: the Definition of Best Educational Practice. *Topics in Early Childhood Special Education*, 1, (1), 45-56.

Winston, P. & Turnbull, A., Blacker, J. (1984). *Selecting a Preschool: A Guide for Parents of Handicapped Children*. Baltimore, MD: University Park Press.



Handouts and Supplementary Materials



Preparing for a Multidisciplinary Staffing

INTRODUCTION

In order to adequately prepare for a multidisciplinary staffing, it will help you to know the purpose of the staffing, who will be there, what will happen, and what your role is. Preparation will help you feel more comfortable and be a more effective team member.

PURPOSE

The main purpose of a multidisciplinary staffing is for the people working with a child to share information and to plan for the future. More specific purposes include discussing results of assessments that have been done, determining program eligibility, discussing progress the child has made, developing goals and objectives for the future (developing or updating the child's Individualized Education Plan or Individualized Family Service Plan), deciding on what services the child will receive and the frequency of those services, and developing strategies to implement a child's program or solve problems.

WHO MAY BE INVOLVED

All professionals who are involved in a child's educational program should attend the staffing as well as the parent(s) or guardian and child care providers. A staffing usually includes the teacher or child development specialist, the speech/language therapist, the occupational and/or physical therapists, and a social worker. Some staffings also include a psychologist, the school principal and/or program director, and representatives of other agencies serving the child and family such as a D.C.F.S. caseworker. It will be helpful for you to be familiar with the various professionals and what they do.

WHAT WILL HAPPEN AT THE STAFFING

Staffings usually begin with each of the team members introducing themselves. The person conducting the staffing will then review the purpose of it. Each member of the "team" will, in turn share any information they have about the child such as:

- what services the child has been receiving
- descriptions of assessment tools used and the results obtained
 - usually given as some kind of developmental level in months or years
- the child's strengths and weaknesses in a particular area
- progress the child has made
- how the child has responded to a particular therapeutic intervention

Each member will suggest future goals, objectives, and intervention strategies in his/her area of expertise. This will include recommendations as to whether a child needs a particular service (e.g. speech therapy), how the service should be provided (e.g. at home, in a special education classroom, or in an integrated setting), and the desired frequency of service (e.g. four times a month).

Participants should feel free to comment on the findings being discussed or to add other pertinent information (e.g. a parent may say that the child can jump down from a four inch height such as the porch or stair even though the evaluator has not seen him do it). The more complete the information about the child is, the more functional the child's program plan will be.

The person conducting the staffing will be putting certain specific kinds of information (test scores, service recommendations, goals and objectives) onto a form or forms called a staffing sheet and/or Individualized Educational Program (I.E.P.) or Individualized Family Service Plan (I.F.S.P.). the final written plan should be agreed upon by all team members, including the parent(s) or guardian. The plan cannot go into effect unless the child's parent(s) or guardian gives written approval. When this plan is completed and approved, all team members sign the form(s) and the staffing is brought to a close.

Staffings are usually done after the initial evaluation of the child (initial staffing), every six months or year thereafter (annual or semi-annual staffings), and upon the transition of the child into another program (final or closing staffing).

YOUR ROLE IN THE STAFFING

Even though you may not do formal testing of a child, your role is essentially the same as any other professional on the team--sharing information. Some specific examples of information you can offer are:

- a description of the child care setting
- how the child functions in a group setting
- how the child interacts with non-delayed peers
- your own assessment information (formal or informal)
- activities the child enjoys/dislikes
- problems you have encountered
- successes you have had (what works for you)

Specific examples to illustrate points or questions are helpful. It will be most efficient if you can jot down notes ahead of time so that important information and questions are not forgotten.

Do not be afraid to ask for clarification of anything you do not understand. Chances are good that if you do not understand something, the parent does not either. Professionals use a lot of confusing terms, and often forget that the general public does not know their particular "shorthand". No one should be embarrassed to ask for further explanation.

Take this opportunity to ask for suggestions on how you can help to implement the child's program and coordinate service with the team members. The person conducting the staffing will usually ask at some point near the end of the meeting, if anyone has any other information, questions, or concerns. If you have not shared everything you feel is important, that is a good time to do so.

FUNDED ILLINOIS CHILD CARE RESOURCE AND REFERRAL AGENCIES

SERVICE DELIVERY AREA
(See Attached Map)

CCR&R AGENCY

CENTRAL
OFFICE

OPERATIONAL CONTRACTS
(Jan. 1, 1990 - June 30, 1991)

II	DeKalb County Coordinated Child Care	DeKalb
III	YWCA of Lake County	Waukegan
IV	YWCA DuPage Child Care Resources	Glen Ellyn
VI	Cook County Child Care Resource & Referral Service, a cooperative venture of Day Care Action Council/ Jane Addams Center	Chicago
X	Child Care Resource Service, University of Illinois	Champaign/ Urbana

PLANNING & DEVELOPMENT CONTRACTS
(Jan. 1, 1990 - Aug. 30, 1990)

I	YWCA of Rockford	Rockford
VII	Community Child Care Resource & Referral Center, a unit of Iowa East Central TRAIN	Quad Cities
VIII	Illinois Central College	East Peoria
IX	McLean County Association for the Education of Young Children/ Catholic Social Services	Normal
XII	United Way of Adams County Consortium	Quincy
XIII	United Way of Sangamon County Consortium	Springfield
XIV	Children's Home & Aid Society	Alton
XV	Rend Lake Community College	Ina
XVI	John A. Logan Community College	Carterville

In Service Delivery Areas V and XI, no applicants were funded. New applications for planning grants in these two SDAs will be issued in early March 1990. Planning and development contracts for these SDAs will run from May 1, 1990 through Dec. 31, 1990.

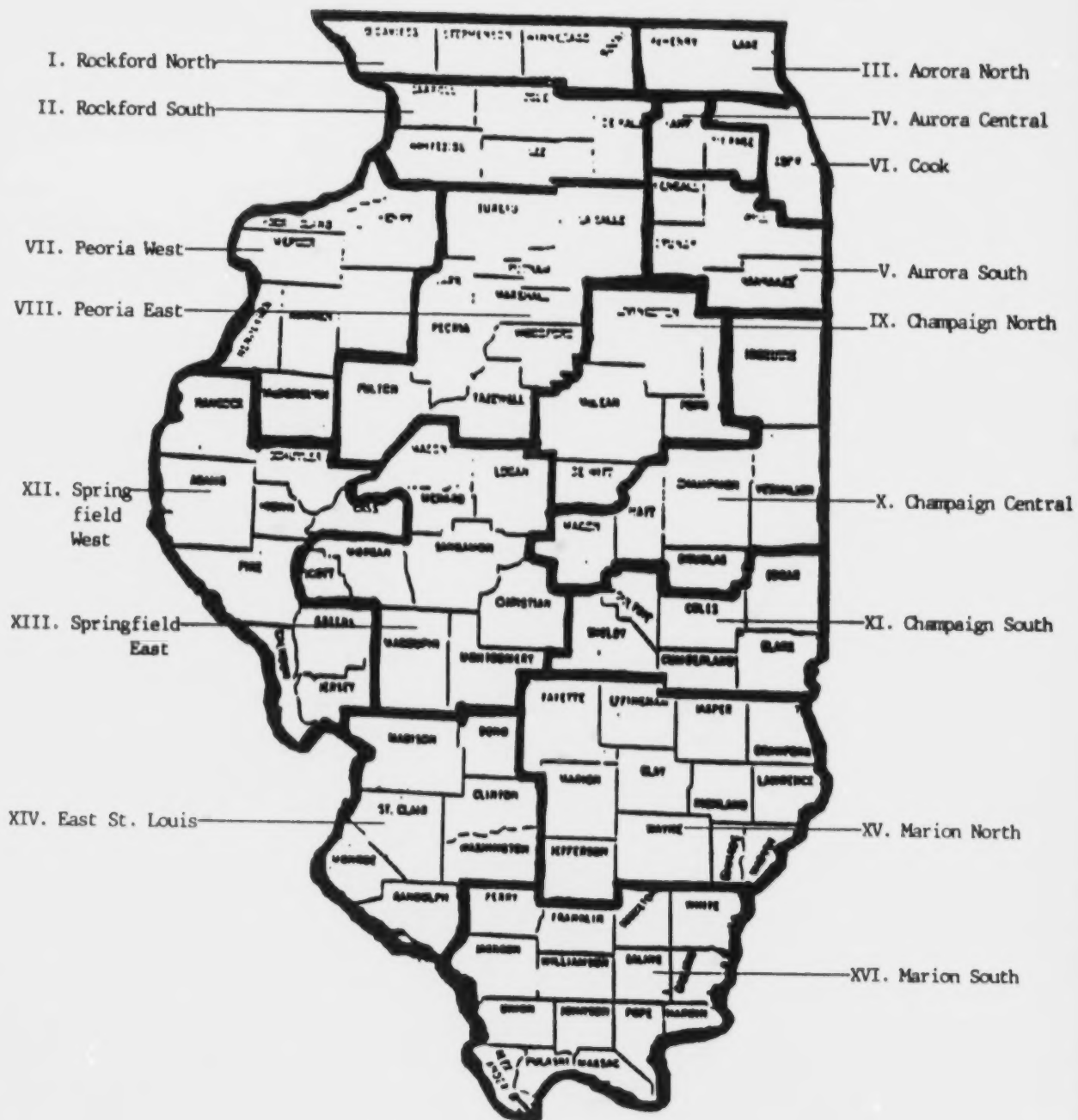
Child Care Resource Organizations
by Service Delivery Area

<u>SDA</u>	<u>Agency Name</u>	<u>Address/City</u>	<u>Contact Person/ Phone Number</u>
I	YWCA of Rockford	220 S. Madison Rockford, IL 61104	Ann Garrity Executive Director (815) 968-9681
II	DeKalb County Coordinated Child Care	145 Fisk Avenue DeKalb, IL 60115	Micki Chulick Executive Director (815) 758-8149
III	YWCA of Lake County	1900 Grand Avenue Waukegan, IL 60085	Diane Philipp Director (708) 662-8670
IV	YMCA of Metropolitan Chicago-DuPage District	739 Roosevelt Road Building 8, Suite 210 Glen Ellyn, IL 60137	Elsie Mills Director (708) 790-6600
VI	Cook County Child Care Resource & Referral Service, a cooperative venture of Day Care Action Council/Jane Addams Center	4753 N. Broadway Suite 726 Chicago, IL 60640	Maria Svihla Executive Director (312) 561-7900
VII	Community Child Care Resource & Referral Center, a unit of Iowa East Central TRAIN	2904 Eastern Avenue Davenport, Iowa 52803	Arlys A. Benzon (319) 324-3236
VIII	Illinois Central College	The Child Care Connection East Peoria, IL 61635	Jan Deissler (309) 694-5553/5248

<u>SNA</u>	<u>Agency Name</u>	<u>Address/City</u>	<u>Contact Person/ Phone Number</u>
IX	McLean County Association for the Education of Young Children/Catholic Social Services	13 Wilmette Drive Normal, IL 61761	Carol Weisheit President (309) 452-6444
X	Child Care Resource Service University of Illinois	528 Bevier Hall 905 S. Goodwin Urbana, IL 61801	Peggy Patten Director (217) 244-5428
XII	United Way of Adams County - Consortium	500 WCU Building 510 Maine Street Quincy, IL 62301	Stephen W. Kinkade Executive Director (217) 222-5020
XIII	United Way of Sangamon County - Consortium	730 E. Vine Street Room 114 Springfield, IL 62703-2553	Charles C. Riddle, Sr. President (217) 789-7000
XIV	Children's Home & Aid Society of Illinois	4601 State Street Suite 330 East St. Louis, IL 62205	Gennie Gilmore Supervisor (618) 874-0216
XV	Rend Lake Community College	Route #1 Ina, IL 62846	Carroll Turner Dean (618) 437-5321 X237
XVI	John A. Logan Community College	Carterville, IL 62918	Mary Ellen Abell Division Chair (618) 985-3741

16 SERVICE DELIVERY AREAS

Child Care Resource & Referral



ILLINOIS LEKOTEK SITES

(* Denotes Compuplay)

Easter Seal Lekotek of Southwestern Illinois
United Cerebral Palsy
1209 N. Illinois Street
Belleville, IL 62221
618/233-0210
Leader--Mary Wescovich

Easter Seal--United Cerebral Palsy
1719 Washington Avenue, Box 219
Alton, IL 62002
618/462-8897
Leader--Bob Hansen

CASE/Champaign's Lekotek Center
(OUTREACH: Charleston/Mattoon, Danville, Effingham, Paxton, Watseka)
1304 W. Bradley Avenue
Champaign, IL 61821
217/351-1008
Leader--Mary Coash

El Valor Lekotek
1924 W. 21st Street
Chicago, IL 60608
312/942-0523
Leaders--Letticia Albarran & Marisabel Campos

Evanston Lekotek Center*
2100 Ridge Avenue
Evanston, IL 60204
708/328-0001
Leaders--Jodi Essey, Kathy Kahn, & Tracy Wilkin

Lekotek in Flossmoor
Good Shepherd Center
2220 Carroll Parkway
Flossmoor, IL 60422
708/957-5703
Leaders--Gretchen Stanicek, Barbara Johnson, & Cynthia Marschner

WSSRA Lekotek*
West Suburban Special Recreation Association
2915 N. Maple Street
Franklin Park, IL 60131
708/455-2100
Leaders--Donna Kwasny & Karen Messner

Galesburg Public Library Lekotek Center
(OUTREACH: Aledo, Cuba, Lewistown, Macomb, Monmouth, New Windsor,
Woodhull)
40 E. Simmons Street
Galesburg, IL 61401
309/343-5358
Leader--Victoria Raistrick

Easter Seal Lekotek Center-Kankakee
895 S. Washington Avenue, Box 84
Kankakee, IL 60901
815/932-0623
Leader-Kathy VanBellehem

Lake Villa Lekotek
Lake Parent Infant Center
215 N. Milwaukee Avenue, Box 430
Lake Villa, IL 60046
708/356-6003
Leaders-Lisa Cutler & Char Slezak

DuPage/West Cook Lekotek Center
Regional Special Education Association
1464 S. Main Street
Lombard, IL 60148
708/629-7272
Leaders-Vikki Daidone & Valerie Fina

Southern Illinois Lekotek Center
(OUTREACH: Benton, Carbondale, Harrisburg, Karnak, Olney)
Southern Illinois Educational Service Center
1107 W. DeYoung
Marion, IL 62959
618/997-4298
Leader-Mary Samuel

LaSalle County Easter Seal Lekotek Center
1013 Adams Street
Ottawa, IL 61350
815/434-0857
Leader-Chris Myers

Easter Seal Lekotek Center-Peoria*
320 E. Armstrong Avenue
Peoria, IL 61603
309/671-5884
Leader-Shirley Strode

Easter Seal Lekotek Center-Normal
206 S. Linden, Suite 4A
Normal, IL 61761
309/452-8074
Leader-Judy Jones

Rock Island Lekotek Center
Easter Seal Foundation
3808 8th Avenue
Rock Island, IL 61201
309/786-2434
Leaders-Marilyn Whiteside & Jennifer Hlavaty

Rockford Lekotek Center
Fairview Early Education Center
512 S. Fairview Avenue
Rockford, IL 61108
815/229-4230

Clearbrook Lekotek Center*
3705 Pheasant Drive
Rolling Meadows, IL 60008
708/392-2812
Leaders-Lynette Law & Judy Ramirez

Lekotek at SMA/McKinley
(OUTREACH: Park Forest)
170th Street & Cottage Grove Avenue
South Holland, IL 60473
708/333-7812
Leaders-Cindy DeVries, Blair Krapf, Beth Limacher, Karen McGinnis, & Cynthia Ward

United Cerebral Palsy of Land of Lincoln Lekotek Center
(OUTREACH: Taylorville)
130 N. 16th Street
Springfield, IL 62703
217/525-6522
Leader-Janet Moulton

Tri-County Lekotek
(OUTREACH: Fulton, Oregon, Rochelle)
Northwestern Illinois Association
3807 Woodlawn
Sterling, IL 61081
815/625-7931
Leader-Jeannette Hielsberg

Southwest Cooperative Foundation Lekotek Center
6141 Kimberly Drive
Tinley Park, IL 60477
708/532-6434
Leaders-Mary Kay Michaels & Donna Pfeifer

SAMPLE REQUEST FOR INFORMATION LETTER

Your Letterhead

Name:

Address:

Date:

Dear _____,

_____ is a new student in the _____
_____ day care program. We would appreciate it
if you could send us any information you have regarding this child that would help us to
meet his/her needs. Cooperating with a child's special service providers is required of
our program by the Illinois Department of Children and Family Services.

_____ will be calling you soon to discuss how we can
best work together to meet this child's needs.

Enclosed is a signed release of information form. Please feel free to contact us if any
further information is desired. Thank you very much for your help.

Sincerely,

SAMPLE RELEASE OF INFORMATION FORM

Your Letterhead

I authorize _____(special service provider)_____
to release _____(type of information)_____
to _____(the name of your program)_____
to exchange _____(type of information)_____
with _____(the name of your program)_____
in regard to _____(child's name)_____
for the purpose of _____(why you want the information)_____

Any information you release to us will be held strictly confidential and will not be released without your permission.

Signature of Parent or Guardian

Signature of Witness

Date

Expiration Date

DSC CHILDREN'S SERVICES SURVEY

Please answer the questions as carefully as you can. You need not sign your name.

GENERAL INFORMATION

A. Current position

1. Student; field of study _____
2. Teacher
3. Teacher aide
4. Administrator

B. If you have worked with children under 5 years of age:

1. Indicate the age group you teach or have taught:

2. Have you ever had a child with special needs/problems in your classroom?

Yes ____ No ____

3. Have you taken any classes describing characteristics and/or teaching methods for exceptional children?

Yes ____ No ____

4. Should students enrolled in teacher education programs be required to take classes describing characteristics of and/or teaching methods for exceptional children?

Yes ____ No ____

MAINSTREAMING

Read the following statements and respond to each using the following scale:

- | | |
|-----------------------|--------------------|
| 1 - Strongly disagree | 3 - Mildly agree |
| 2 - Mildly disagree | 4 - Strongly agree |

Mainstreaming is the practice of including children with handicaps in regular classrooms.

	SD	MD	MA	SA
1. In general, mainstreaming is a desirable educational practice.	1	2	3	4
2. All children should have the right to be in regular preschools.	1	2	3	4
3. It is feasible to teach gifted, normal, and mentally retarded children in the same preschool.	1	2	3	4
4. Educable mentally retarded children should be in a regular preschool.	1	2	3	4
5. Visually handicapped children who can see standard picture book material should be in regular preschools.	1	2	3	4
6. Blind children who cannot see standard picture book material should be in regular preschools.	1	2	3	4
7. Hearing impaired children who are not deaf should be in regular preschools.	1	2	3	4
8. Deaf children should be in regular preschools.	1	2	3	4
9. Physically handicapped children confined to wheelchairs should be in regular preschools.	1	2	3	4
10. Physically handicapped children <u>not</u> confined to wheelchairs should be in regular preschools.	1	2	3	4
11. Children with cerebral palsy who cannot control movement of one or more limbs should be in regular preschools.	1	2	3	4
12. Children who stutter should be in regular preschools.	1	2	3	4
13. Children with speech or language problems should be in regular preschools.	1	2	3	4

- | | | | | |
|---|---|---|---|---|
| 14. Children with epilepsy should be in regular preschools. | 1 | 2 | 3 | 4 |
| 15. Children with diabetes should be in regular preschools. | 1 | 2 | 3 | 4 |
| 16. Children with behavior disorders who cannot appropriately control their own behavior should be in regular preschools. | 1 | 2 | 3 | 4 |
| 17. Children who present persistent discipline problems should be in regular preschools. | 1 | 2 | 3 | 4 |
| 18. Mainstreaming will be sufficiently successful to be retained as a required educational practice. | 1 | 2 | 3 | 4 |

Comments:

PRESCHOOL INTEGRATION INVENTORY

Teachers are ordinarily faced with a wide variety of problems arising from the many different kinds of children they work with each day. Below, you will find brief descriptions of the behavior of a number of exceptional children. In each case, you are to indicate how you would prefer to handle the situation if the decision were entirely up to you. Read each item and circle the letter that corresponds to the appropriate description at the top of each page.

NA = No Assistance. You could handle such a child in your regular day care without any fundamental change in your present procedures.

SA = Some Assistance. You could handle such a child in your regular day care, provided advice from a specialist or consultant was made available to you whenever you felt the need for such aid in dealing with some particular problem.

ST = Supplementary Training. You could handle such a child in your regular day care, provided there was a full-time specialist or consultant available at your center who could provide supplementary training for the child and frequent consultation for you.

AP = Alternative Placement. This child would not be an appropriate candidate for your day care. The child would benefit most from being assigned to a special class or program.

1. — John is defiant and stubborn, likely to argue with the teacher, to be willfully disobedient, and otherwise to interfere with normal preschool discipline.
2. — Barbara wears thick glasses, and her eyes jerk spasmodically from side to side; she can't see the materials at group time very well.
3. — Chuck can get about only in a wheelchair; someone must move it for him or carry him in their arms, because he is unable to control any of his limbs.
4. — Donald is 4 years old and does not speak much. What he does say is indistinct and babyish, with many missing or incorrect sounds.
5. — Terry is 9 months old and has Down Syndrome. She seems very happy but does not yet crawl or hold her own bottle. She has frequent ear and respiratory infections.
6. — Joey is 2 years old and has cystic fibrosis. He coughs continually and must have aerosol inhalation therapy 2 to 3 times a day.

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ST = Supplementary Training. You could handle such a child in your regular day care, provided there was a full-time specialist or consultant available at your center who could provide supplementary training for the child and frequent consultation for you.

AP = Alternative Placement. This child would not be an appropriate candidate for your day care. The child would benefit most from being assigned to a special class or program.

7. — When Alice wears her hearing aid she hears as well as any other youngster. Her voice sounds hollow and flat and is somewhat unpleasant to hear.
8. — Erica can walk by herself, but she falls frequently. She also has difficulty using her hands to perform such tasks as cutting, coloring, buttoning, and printing.
9. — Alan wears a leg brace and walks with the aid of crutches. He gets along quite well by himself and ordinarily needs no help from anyone.
10. — Tommy is 2 years old and does not yet say single words. He is easily frustrated and uses some gestures for communication.
11. — Lisa is 15 months old. She has mild developmental delays and has very limited use of the right side of her body, although she can walk.
12. — Susie is 9 months old and vomits frequently because she has had a problem with metabolizing food. She is on a restricted diet and lacks energy.
13. — Chuck seems not to catch on to things as quickly as most and needs to have things explained again and again. Eventually he appears to learn everything the others do, even though it takes him longer.
14. — Jonathan is 22 months old and does not yet walk or say single words. He is highly distractible and has a very short attention span. He is constantly in motion. He uses baby mouthing and frequently puts things in his mouth.

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ST = Supplementary Training. You could handle such a child in your regular day care, provided there was a full-time specialist or consultant available at your center who could provide supplementary training for the child and frequent consultation for you.

AP = Alternative Placement. This child would not be an appropriate candidate for your day care. The child would benefit most from being assigned to a special class or program.

15. — Jane can tell the direction from which the sunshine enters her classroom. She cannot see the pictures in an ordinary storybook.
16. — Cindy is 18 months old and has cerebral palsy. She cannot sit well on her own, and requires several pieces of adaptive equipment. She must be fed babyfood, since she cannot feed herself or eat solid food.
17. — James is a 5 month old with lower than normal muscle tone; he rolls in either direction; he is able to sit, supported, but with a rounded back. His cognitive and language skills are like those of a 6 month old.
18. — Virginia hears most things said in class, but not everything, even though she wears a hearing aid.
19. — Ben is unable to walk and has been confined to a wheelchair. He manages this very skillfully and needs very little help.
20. — Les was born with a malformed left hand which is withered and mishaped up to the elbow.
21. — When Terry was 2, he was run over, losing the use of both his legs and genitals. He gets around quite well now, but his bladder discharges into a bag which must be emptied several times a day.
22. — John has no difficulty on the playground or at group time, but he becomes quite uncomfortable when he has to use his eyes at close range for anylength of time.
23. — Jay is a two year old. The right half of his body is tight and uncoordinated. He requires assistance in dressing and in using fine motor materials and has difficulty with stairs. Without supervision, he falls frequently.

24. — Eugene is a one year old who is unsteady in sitting,
is learning to crawl, and is mostly deaf.
25. — Samuel is a 9 month old whose development is like that
of a 4 month old. His cleft palate has been surgically
repaired, and his seizures are controlled with medication.

**TRAINING NEEDS ASSESSMENT
FOR
CHILD CARE PROVIDERS**

A. YOUR POSITION

1. What is your position title? _____
2. What age group do you work with? _____
3. What is the group size? _____
4. How many hours a day do you work with the children? _____

B. YOUR PROFESSIONAL TRAINING/EXPERIENCE

1. How long have you been in your present position? _____
2. How much total professional experience have you had with:
 - a) 0-3 year old children: _____
 - b) 3-5 year old children: _____
 - c) school-age children: _____
3. Have you had any experience with children with special needs? _____ yes _____ no

Describe _____

4. What is your educational background?

<u>Year</u>	<u>Degree</u>	<u>Major</u>	<u>Professional Certificate</u>

5. Do you have any special training or skills? If so, please describe. _____

6. Have you taken any courses or gone to any workshops dealing with special needs? If so, please describe. _____

C. TOPICS OF INTEREST FOR IN-SERVICE TRAINING OR INFORMATION
(check those you would like to know more about.)

- _____ the special needs of a child I'm working with
_____ information about normal cognitive development
_____ information about normal speech and language development
_____ information about normal social/affective development
_____ information about normal physical/motor development
_____ what makes a child "high risk"
_____ influence of high risk or disabled children on families (including siblings)
_____ how to involve families in my program
_____ rules and regulations governing special services
_____ communication skills for working with other professionals
_____ how to evaluate and improve my day care home or center program
_____ how to do the Denver Developmental Screening Test
_____ how to identify children who might have special needs
_____ how and where to refer children that I have concerns about
_____ how to talk to parents about concerns
_____ how to adapt activities according to the needs of a special child I'm working with
_____ behavior management
_____ ways to help a child develop speech and language skills
_____ ways to help a child develop motor skills
_____ ways to help a child develop social skills
_____ how to work with a child with special health care needs
_____ child abuse and neglect
_____ how to work with abused and/or neglected children
_____ how to integrate children with special needs into a regular day care setting
_____ attention deficit-hyperactivity disorder (AD-HD)

- _____ using the New Friends or Kids on the Block programs
_____ how to explain the needs of a child who is different to the other children/parents.
_____ other--please describe: _____

D. TRAINING OPTIONS

1. Please list several high priority areas or topics (use #1 as top priority):

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

2. What would be the best way to provide training for you?

- _____ naptime workshop(s) in your center or home
_____ evening workshop(s)
_____ Saturday morning workshop(s)
_____ provide reading material

THANK YOU FOR YOUR HARD WORK AND TIME!

Date Written _____

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DEVELOPMENTAL SERVICES CENTER

Teacher In-Service Plan (TIP)

Teacher Name JanTrainer NancyCenter Little Kids' PlaceDate Written 1/87[illegible]

ILLINOIS DAY CARE TRAINING CONTRACTORS

Service Area 1 (Rockford, Aurora, Peoria):

Jan Deissler, Project Coordinator
Illinois Central College
1 College Drive
East Peoria, IL 61635-0001
309/694-5553
309/694-5248

Service Area 2 (Chicago):

Doris Fields, Project Coordinator
Department of Human Services
Children's Service, 7th Floor
500 N. Peshtigo Court
Chicago, IL 60611
312/744-7256

Maria Svihia, Executive Director
Peggy Reihl, Project Coordinator
Day Care Action Council
4753 N. Broadway, Suite 726
Chicago, IL 60640
312/561-7900

Carla Berry, Ed.D., Executive Coordinator
Chicago Association for the Education of Young Children (CAEYC)
410 S. Michigan Avenue, Suite 525
Chicago, IL 60605
312/427-5399

Service Area 3 (Springfield, East St. Louis):

Lucy Campanis - Project Coordinator
Eastern Illinois University
School of Home Economics
Charleston, IL 61920
217/581-2124

Jane Ozier- Project Associate
Eastern Illinois University
School of Home Economics
Charleston, IL 61920
217/581-2124

Service Area 4 (Champaign, Marion):

Nancy Morse - Project Coordinator
Parkland College
Child Development Program
2400 W. Bradley Avenue
Champaign, IL 61821
217/351-2229

Section III - *Families of Children with Special Needs*

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Handouts and supplementary materials



Section III - Families of Children with Special Needs

THE FAMILY: OUR PARTNER IN CARING FOR THE CHILD

The child who comes to us for day care services does not come out of a vacuum, but out of a family. Our success in accomplishing what we want to accomplish for and with that child will be determined by how well we form a partnership with the child's family.

It is impossible to generalize about the kinds of resources that families will bring to this partnership, or even about whether they are willing or reluctant partners. Some families will have become extremely well informed about their child's disability and will be happy to play a key role in educating us. Others will know very little or will prefer to act as if the child has no special needs. Some have had plenty of money and emotional support to cope with the child's special needs. Others have been impoverished by medical bills, seen their social circles reduced and their marriages damaged or destroyed since the arrival of a child with special needs.

THE EFFECTS OF HAVING A CHILD WITH SPECIAL NEEDS

One thing we can generalize about: no matter what resources a family has, the presence of a child with special needs always places additional stress on that family. When a child with special needs is born or a child is diagnosed with a disability, the parents grieve for the loss of their "perfect" child and all the plans and dreams they had for him or her. Parents go through a "grief cycle" where they experience shock, denial, anger, blame, guilt, and finally acceptance. These feelings do not necessarily occur at any one time or in any particular order, but are exhibited at many different periods in the life of the child. These feelings seem exceptionally strong in transitional times such as birthdays, moving from a birth to three program to a school based program,

or when a younger sibling passes an older, disabled child developmentally. Sometimes negative feelings are directed toward a child care provider. A parent can deny to himself that the child is delayed, and thus be angry at the child care provider that suspects a problem. This is sometimes the case when a child care provider is the one to initially suspect or identify a problem. It also occurs when a child care situation does not work out for the child. A caregiver can be blamed for the child's inability to cope with the child care situation. The parent may feel guilty that he put his child through this difficult experience. Sometimes parents feel guilty about the child's disability or their own need to work, and show this by being overly cautious or protective of the child. It is important that a caregiver understand and respect these feelings in parents.

How a handicapping condition affects the stress level of the family is influenced by many factors such as the type and severity of the handicap, the age and sex of the child, the ability of the child to respond to adults, the difficulty of caring for the child, and the resources and support that the parents have.

DAY CARE FOR CHILDREN WITH SPECIAL NEEDS

Over 50% of children live in homes where both parents or a single parent are employed outside the home. Children with special needs are no exception. In fact, the added costs involved in meeting the needs of a child with a handicapping condition or other type of special need may force even more parents into the work force. Many mothers who may have stopped working to stay home to rear children find that they cannot do so because they may be unable to get health insurance for their child in any other way. It is safe to assume that many children with special needs will need day care. They may need day care for

Section III - Families of Children with Special Needs

more years than a child without special needs. High quality day care for children with special needs is even more crucial than for other children. Finding a program that can meet the needs of children with anything more than minor disabilities is a major problem for working families. Unfortunately, it is often the programs that are having trouble maintaining their enrollment due to their poor quality that will accept "any kid". Contrary to popular belief, there is NOT special day care funding available for children with handicapping conditions. Add the financial stresses caused by the high costs of day care, medical care, and insurance to the difficulty of finding ANY child care (let alone quality child care), to the grief and extra effort that may be involved in raising a child with special needs, and you have an extremely stressful situation for the parent(s) of a child with special needs.

FAMILIES MAY USE DAY CARE FOR DIFFERENT REASONS THAN OTHER FAMILIES

Parents whose children have special needs--especially mothers, who tend to be the primary caretaker if there are two parents in the household--may not have had the opportunity to work or develop careers similar to other parents with similar backgrounds and children of similar ages. Parenting a disabled child may have become their only "career". Their reason for seeking child care may therefore be different from other parents. As in the STORY OF TANIKA, the day care placement may be part of the child's educational program, rather than for the purpose of parental employment. In the case of a school-age child who attends a segregated educational placement all day long, the parent may desire after-school child care or summer care in a regular community-based setting for the purposes of giving the child a mainstreamed recreational experience. Or in some cases, the day care

placement may indeed be for the parents' own needs--but it may not be for the traditional purposes of employment, training, or schooling. Day care may be used as respite--allowing parents to rest up from the wearying task of raising a child with disabilities, or managing the behavior of one who is difficult to control.

Of course, some parents whose children have special needs do apply for day care for the very same reasons as any other parent--because they have full time jobs and need a place for the child to be safe and cared for while they are employed. But the fact that many such parents have different reasons has important implications for day care providers, and are worth thinking about.

First, are your policies sensitive to those who are not working? Do you give priority to those who are working full time, thus overlooking the fact that parents of a disabled child may never have had the kind of care available to allow them to seek full time work? Do you give priority to those who want care for their child five days a week? What about the parent who needs two days a week for respite?

Second, how does this affect your relationship with the parent? At first, you might be very pleased to meet a parent who is extremely interested in the ongoing activities at your program--since so many other parents seem too busy to notice. But after spending forty-five minutes with the parent every day for a week, plus a phone call or two during nap time, you realize something; "This may never end...she isn't working...keeping an eye on me and my staff is her job!" To avoid becoming resentful, you will have to learn to set limits, and to cultivate a communication style that allows for active participation by the parent without exhausting you or interfering with other responsibilities.

Third, you may find that parents are not as open

Section III - Families of Children with Special Needs

with information as you would like. They may tell you about Jennifer's mental retardation but not about her seizures. This is not because they are dishonest people, but because they have learned through bitter experience about discrimination. They know she hasn't had a seizure for over a year, and may never have one again in her life; but they are afraid you will not accept her if you know she used to have them. You will need to develop procedures for dealing with information like this which may not come to you at the time of enrollment, but which comes to you in bits and pieces over the course of time.

It is very important that the staff of a child care center discuss and understand the various ways that some families of children with special needs are bringing different histories and different issues with them to the child care setting. Without this understanding, the perception of these differences may lead to resentments. ("Why didn't they tell us about the seizures? They obviously don't respect us as professional!" "Can you believe Mrs. J...brought Cecille here on Veterans Day, when all we had was a skeleton staff--and she doesn't even work on regular days, let alone holidays...") With greater understanding, a much better, mutually respectful partnership can be formed.

DAY CARE AND FAMILY SUPPORT

All families need support, not just families of children with special needs, or families of children in day care. Caregivers sometimes wonder if they are becoming social workers. More and more families with special needs seem to be coming to them. The Department of Children and Family Services often places children of parents in stressful situations in day care as a respite for the parent. It is felt that a parent may need time to relax and get in control of his or her life. Perhaps the child himself is difficult. Care-

givers need information about how they can work with the child and the family to best serve the needs of the child. They may feel that they have enough to do to worry about the child. If caregivers understand that the family is a system, they will see that the child cannot really be served apart from the family. Everything that affects the family will affect the child. By helping to support the family, a caregiver is also supporting the child. It can also make their job easier.

Some ways that day care providers can support families are listed below. This is not a complete list as each family has unique support needs:

- Provide families with information on child development. This information can be provided in a variety of ways such as informal conversations, pamphlets, bulletin boards, workshops, etc.*
- Build confidence in parents. Point out what they are doing well, and how this is affecting the child.*
- Help reinforce the parent-child relationship. Make parents aware that working or being apart during the day does not decrease the amount of attachment that is felt between the child and parent. Tell parents about positive things the child said about them during the day. Point out the child's good qualities to the parent (e.g. "Tammy is the fastest runner in the class!").*
- Don't criticize.*
- Give parents the opportunity to use their talents (e.g. make cookies, fix a toy, play guitar for the children, do the laundry for the class, etc.).*
- Link families to other community resources such as a respite care program, public health program, developmental screening program, mental health program, etc.*

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-Help parents to develop a social network within the child care setting. This might involve introducing a more isolated parent to a more outgoing parent, providing opportunities for family social occasions through the child care program, providing a place for parents wishing to have a parent support group, etc.

-Treat parents as partners. In many ways day care is taking the place of the extended family in today's highly mobile society.

-Accept parents as they are. Assume that parents want the best for their child(ren), and that they are doing the best they can in the life situation they are in.

-Be a good listener whenever possible. Don't give too much advice or ask too many questions.

-Provide quality child care. Letting parents know that their child is happy, secure, and well cared for while they are at work or taking care of others' needs is the most important way to help families cope with the stresses of their day to day life.

HELPING FAMILIES CHOOSE AND USE CHILD CARE

Identifying Needs

The first thing a family needs to do when searching for child care is to identify their needs. Resource and referral services usually ask very specific questions about child care needs. What hours are needed? What location is preferred (close to work or home)? How much can the family afford to pay, or who is going to pay for the child care? What is the age of the child needing care? How will transportation be provided? How many children in the family need care?

The family should identify the child's needs. Does the setting need to be wheelchair accessible? Does the child need specialized care such as tube feeding? Will the child need to receive therapy services at the child care setting? Does the setting need to be in a certain location in order for the school bus to provide transportation? Does the child need a small group rather than a large group? Is it better for the child to be with children of his own developmental level, his chronological age level, or to be in a family grouping? Does the caregiver need to know or be willing to learn sign language? Other questions that may need to be asked will depend on the individual child and his family.

Locating Child Care for Children with Special Needs

The State of Illinois is currently developing a statewide resource and referral network. It would be most helpful to parents of children with special needs if these agencies could develop a list of child care providers who have experience serving children with special needs. Resource and referral services ask providers if they have served children with special needs. Providers inform them of any special training such as sign language or a nursing background. Early intervention agencies and public school special education departments may have lists of child care providers that have served their children. Many park and recreation departments as well as schools are developing after-school programs that better serve all children. Parents are also encouraged to call the Department of Children and Family Services (if a resource and referral service is not available), to look in the newspaper, to ask friends and acquaintances for suggestions, to place ads in the newspaper, and to use college bulletin boards.

When talking to potential child care providers, parents and others seeking care for a child with special needs should be advised to describe the abilities and disabilities of the child for whom

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child care is sought. Labels such as "cerebral palsy" or "autistic" can be misleading because many people who have not had experience with children with special needs are not aware of the wide range of capabilities that are possible. Parents should be very honest about a child's specific needs. This will enable the provider and the parent(s) to better evaluate the child's ability to function in the setting and the provider's ability to meet the special needs of a particular child. For example, many children with cerebral palsy do not need to attend a program that is "wheelchair accessible". A provider may be under the mistaken impression that she cannot serve children with cerebral palsy cannot be served because the program is in a basement.

Evaluating Child Care

Unfortunately, there are parents who spend more time looking for the best rump roast than they do looking for the best child care. Many parents do not know that they have a choice. They do not know how to identify quality care for their child. Some parents choose a child care provider without even meeting her. Some child care providers will enroll a child with special needs in their program without seeing the child or evaluating whether or not they can adequately meet the child's needs. These are big mistakes for all concerned. Many parents need guidance in choosing the best child care available. Sometimes all that is needed is information on choosing child care which can be obtained from the local D.C.F.S. office or Resource and Referral Service. Some parents will need more help. If this is the case, perhaps special service personnel could offer to visit a day care program with the family.

The family needs to look at the kinds of interactions that occur between children and caregivers, specifically the caregivers that will be working with their child. A provider can have a beautiful facility or home with everything a child could

need or want, but if the program is not warm and supportive in meeting a child's needs, then it is a poor program and the child will not be happy. The best recommendation that can be given to parents is to find a caregiver that has an approach to working with children that is as close to theirs as possible. The parents and children will be more comfortable in this kind of situation.

Parents should consider whether or not a child can handle a particular setting. Children with neurological or sensory impairments often feel overwhelmed in a noisy setting with a large number of children. It can be very difficult for a child with special needs if he never experiences success in the child care setting. He needs to be able to have friends that he can relate to in some way. Parents should also make sure that caregivers are willing to cooperate with special service providers to reinforce the child's goals and objectives.

Using Child Care

Professional child care, in some ways, is a relatively new phenomenon in our society. Parents may be unsure as to what their role is in dealing with day care providers. A child care consultant should encourage families to think of caregivers as partners in child-rearing, not just as "babysitters" who are just doing this for the money. Parents should not take advantage of caregivers. It is essential to follow guidelines set up for parents. Picking up the child on time and calling when the child is ill or will not be at the center or home that day, are important parts of this consideration. Some parents think that if they have paid for a time period, then the caregiver should be able to take their child at any time during that period. In part, this is true, but most caregivers have some kind of daily schedule they follow which gives structure to the children's day and lets them know what to expect. It also helps caregivers to meet children's needs more effectively. Outings may be planned. Disruptions in

Section III - Families of Children with Special Needs

the daily routine can be difficult for some children, especially those with special needs.

Parents should be encouraged to keep in close contact with child care providers. They should let caregivers know what kind of night the child had or if he ate much breakfast. Parents should let caregivers know if something has happened to disturb the child. They should share effective methods of feeding and discipline. Parents should feel free to ask how the child is doing or how their day was. Whenever possible, parents should let caregivers know when there has been a change in the child's routine. Caregivers should know, for example, that Janie has physical therapy on Tuesday mornings so she may be more tired on those days.

The day care consultant should also let parents know what kinds of information she is giving to caregivers. An example of a note that was left for a parent after a consultation visit to a center is included at the end of this section. Whenever possible, the consultant should give parents copies of any written material that is shared. The day care consultant can give parents a realistic description of how the child is doing at day care. Parents often feel more free to discuss their concerns about the child care setting to an outside observer. Reassuring parents that things are going well can be very helpful. If possible, a consultant could videotape the child at day care and let parents actually see what the child is doing when they are not there.

SIBLINGS OF CHILDREN WITH SPECIAL NEEDS

The sibling relationship is a major component of the family system. Often parents must spend a great deal of their time taking care of, or paying attention to a child with special needs. Sometimes this takes away from the amount of atten-

tion given to siblings. Parents may become "pre-occupied" with the special needs child. The less obvious but no less important needs of the "normal" sibling can sometimes be overlooked by even the most sensitive parent. Siblings may feel responsible for the child's disability. For example, young children, especially, are very egocentric and may think that a sibling was born with a disability because they did not want a babysitter. A sibling may feel guilty for not being disabled. Fear of the unknown is often in the forefront for siblings. They wonder what will happen to their sibling in the future. If the sibling is hospitalized, they may wonder if he is going to die. These concerns place a lot of stress on a child. Caregivers need to know how to respond to their needs.

Having a sibling with special needs affects individual children in different ways. One child may become a "superkid" who tries to get attention by being perfect and helpful as can be, while another may become a behavior problem because this is the only way he can get attention. Children respond to their parents' anxieties. Even when they do not understand what is happening, they sense that something is not right. When parents are in stressful situations, they sometimes do not see the siblings' feelings as important.

Some things that caregivers can do to support siblings of children with special needs include offering them as much extra attention as possible, especially when the family is going through a difficult period. Don't give the "superkid" too much responsibility as he is probably getting a lot at home. When a child is upset, reflect his feelings. Give him words for feelings he may not understand. Give the child as much correct information as you can about the sibling. Make sure to talk to parents to see what kinds of things they have told the child. Respect their wishes in what they want the child to know, and how they want the information to be communicated. Be

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aware of signs of stress. See the module on social-emotional needs for more information on this. Let the child play! Include stress relieving activities such as waterplay, playdough, art activities, active gross motor times, etc. Build the child's self esteem by giving him success experiences and positive messages about himself. If the child is having difficulties that you feel need more attention, discuss this with the family. Refer the family to mental health service providers or to the school social worker. Some agencies serving people with disabilities have sibling support groups for children. This may be a helpful thing for even the most well-adjusted sibling.

RESOURCES

Families and Disability Newsletter
The University of Kansas
Beach Center on Families and Disability
Bureau of Child Research
4138 Haworth Hall
Lawrence, KS 66045
Phone: 913/864-7600

Sibling Information Network
Connecticut's University Affiliated Program on Disabilities
991 Main Street, Suite 3A
East Hartford, CT 06108
203/282-7050

Especially Grandparents (newsletter)
2230 Eighth Avenue
Seattle, WA 98121

For Sibs Only (ages 4-9)
and Sibling Forum (ages 10 & up) - newsletters
Family Resource Associates, Inc.
35 Haddon Avenue
Shrewsburg, NJ 07701

The Exceptional Parent Magazine
Psy-Ed Corporation
1170 Commonwealth Ave.
Boston, MA 02134

Programs to Strengthen Families (resource guide)
Family Resource Coalition
230 N. Michigan Avenue
Suite 1625
Chicago, IL 60601
312/726-4750

REFERENCES

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Zeitlin, S. & Williamson, G.G. (1988). Developing Family Resources for Adaptive Coping. *Journal of the Division for Early Childhood*, 12(2), 137-146.



Handouts and Supplementary Materials



CHECKING OUT THE PRESCHOOL

Concerns for the Child with Special Needs

Teacher qualifications

- What type of college training does the teacher have?
- Has the teacher taken special courses related to the education of handicapped children?
- Are workshops or training opportunities available for the teacher through the year? How does the teacher feel about his or her ability to teach handicapped children?

Teacher's interactions with children

- Does the teacher smile and look directly at the children when talking with them?
- Does the teacher appear to be physically relaxed with the children when touching, talking with, and approaching them?
- Do the children appear to trust the teacher and freely turn to her or him for help, information, and comfort?
- Is the teacher skilled at communicating with non-verbal children? Does she know sign language? Is she sensitive to non-verbal cues, such as gestures, facial expressions, postures?
- Where does the teacher appear to spend most of her or his time--working with children; talking with other adults, parents or staff members?
- Does the teacher display humor and common sense in dealing with children?
- Does the teacher seem to be easily hassled if things are not going right?
- How does the teacher reward and discipline a child?
- Do you feel comfortable with these methods?
- Is the teacher's talk with the children heavily sprinkled with do's and don'ts?

Teacher's attitudes toward individual needs

- Do the teacher's expectations and treatment differ for girls and boys?
- Did the teacher have classroom experience with handicapped children? Did the handicapped children formerly in the teacher's class have special needs similar to those of your child?
- Does the teacher's attitude and the preschool reflect through the selection of pictures, photographs, and books an awareness of and respect for ethnic and cultural backgrounds?
- Does the teacher categorize children?
- How does the teacher describe his or her approach to meeting the individual needs of each child? Do you think the teacher will be able to meet your child's needs?

Individualized instruction

- How many children are in the class? How many instructors? (Instructors might include teacher aides, parent volunteers, older students.)
- Does the ratio of children and instructors seem to be reasonable?
- Are children grouped for instruction according to skill level or chronological age? Are groupings flexible?
- Are special materials and equipment available for children with handicaps (prone standers, corner chairs, braille readers, books in large print)?
- Do children's needs in different skill areas seem to be taken into consideration?

The arrangement of space in the preschool

- Is there enough space for the number of children? Is it divided? Is there an outdoor play area?
- If space is divided, who goes where? Is the division made by age, sex, interest, types of handicap? Are there small areas where a child can go to be alone?
- Are furniture and equipment arranged in such a manner that your child can crawl, walk, or navigate in a wheelchair?
- Are there spaces for children to work or play quietly and actively with materials and equipment?
- Are there adequate areas and facilities for children to rest and sleep?
- Are there special areas for a variety of activities: blocks, reading, dress-up arts and crafts? Are the potentially noisy and active areas (blocks, jungle gyms, housekeeping center) separated physically from the quiet areas (books, puzzles, art centers)?
- Are there areas where specialists (for example, speech therapist, physical therapist) can work with children and teachers?
- Is the preschool building, including bathrooms and playground, accessible to children with mobility impairments?

Related support services

- Are related services (such as speech therapy, physical therapy, occupational therapy, mobility, and orientation training, audiological services, counseling and health services) needed by your child currently available?
- How frequently and for what period of time are related services available?
- Who provides the related services? What is the relationship between the teacher and related-service providers?
- Are services offered individually or in small groups?
- Is the teacher willing to follow up in the classroom on recommendations from related service providers?
- Is funding for related services a certainty?
- If related services are not currently part of program, does the staff know how to find and use community resources?

Emotional and social climate of preschool

- Who is the primary population being served? (Observe the classroom and get to know the characteristics of children currently enrolled.)
- Do the children appear to be comfortable and free with other children in the group, or are there numerous fights and disturbances?
- Do the children encourage one another, appear to play well with others in the group, work cooperatively among themselves? Do they do these things without constant interference from adults?
- Does the teacher help to mediate potentially explosive situations such as fights over toys, name-calling, or physical aggressiveness?
- Do opportunities exist for handicapped children to interact with non-handicapped children in the classroom? Do such opportunities exist outside the classroom?
- How do handicapped children in the program interact with each other?
- Does the program provide opportunities for the children to experience risks-physical and emotional? Is the program overly protective and specialized for your child?
- Do teachers encourage independence? Are children permitted to test their physical abilities and master difficult tasks with teacher supervision?

-Are children encouraged to work without teacher attention or reinforcement for some parts of the day?

Keeping track of child's progress and development

- Are children assessed in all developmental areas such as speech and language, social, emotional, and physical development?
- Are annual goals and short-term objectives formulated in all developmental areas?
- How frequently is the progress of children monitored? How frequently and in what way is this information shared with parents?
- Are parents involved in helping to plan the child's educational program?

CONCERNS FOR THE PARENT

Professionals involvement so parents can relax

- Can parents trust teachers to do a good job teaching the child? (This will have to develop over time, but do the basic elements of trust seem to be present?)

Frequent contacts with teacher

- Are teachers willing to engage in frequent interactions with parents?
- Are opportunities available for you and the teachers to have frequent interactions (for example, at drop-off or pick-up times)?
- Do teachers seem to be willing to listen to what you have to say (including feelings of frustration, resentment, inadequacy or anger) in an open, non-defensive and non-judgmental manner)?
- Are parents free to drop in and observe the classroom?

Parent counseling

- Do staff members provide counseling, or is this service provided through other community resources?

Parent training

- Does the program provide opportunities for improving parent-child interaction (workshops to increase parents' knowledge and skills, opportunities to observe staff members and learn educational techniques from them)?

Program participation

- Does the program provide opportunities for parent participation (advisory board membership and decision-making opportunities to volunteer as an aide in the classroom or with a special project outside of the classroom)?
- Are participation opportunities available for all family members (fathers, siblings, grandparents)?

Contacts with other parents

- Are structured opportunities available to meet with other parents who may share your feelings, perspectives, and needs (parent support groups, potluck dinners)?
- Are unstructured opportunities to meet with parents available (drop-off and pick-up arrangements which encourage parent interaction, having a quiet place with a coffee pot and a parent bulletin board)?

Cost of program

- What is the cost of the program? (The local school system is financially responsible if educational services for handicapped children ages 3 to 5 are legally mandated in your state.)
- When are tuition payments due?
- Are scholarships available?

Convenience of program

- How far is the program from your home?
- Are parent car pools encouraged, supported, or available?
- Does the preschool provide bus service? What is the cost?

Is daycare provided?

- What are the preschool's hours of operation?
- Is a full-day program an option?

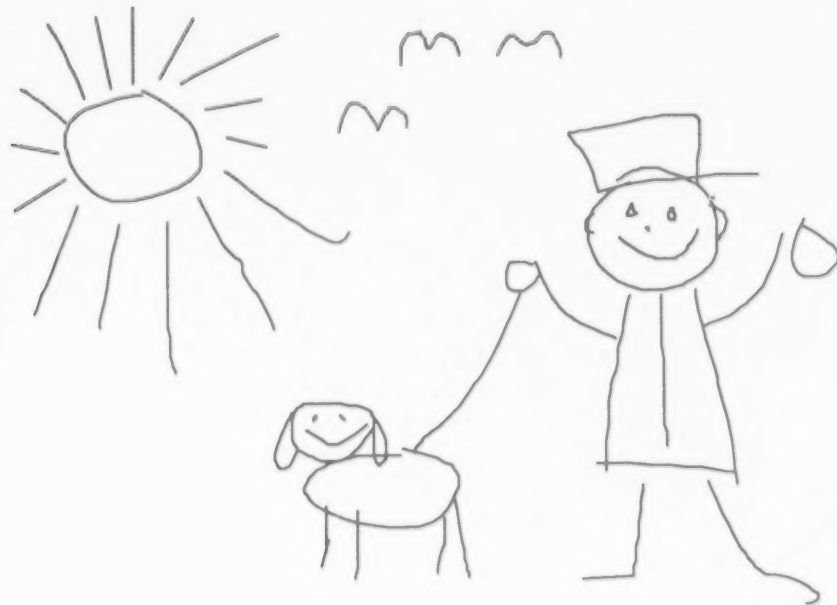
Adapted from *Choosing a Preschool: A Guide for Parents of Handicapped Children*, by Pamela Winton, Ann Turnbull, and Jan Blacher. Austin, Texas: Pro-Ed, 1984.

Section IV - Workshop Series Outlines

Developing and facilitating workshops	page 1
Workshop organization and outlines:	
I - Identifying children with special needs	page 5
II - Introduction to handicapping conditions	page 11
III - Communication skills	page 15
IV - Behavior management	page 21
V - Family involvement	page 31

Handouts and supplementary materials

(at the end of each workshop)



Section IV - Workshop Series Outlines

DEVELOPING AND FACILITATING WORKSHOPS

Assessing Needs

Well trained staff are the most important component of any program, but this is especially true of programs that provide care for children. In order to guarantee that the program staff has consistent training, many programs have turned to inservice training sessions.

The first step to follow is to carefully evaluate the program to determine if inservice training seems to be indicated and, if staff training is indicated, to determine what the specific areas of training should be. Several approaches can be used to determine program needs. Among these approaches are: 1) systematically observing the program in progress, 2) asking staff to complete a staff questionnaire, or 3) interviewing staff members.

When evaluation is approached from the perspective of self-evaluation and input is solicited from all the staff, program evaluation can create a positive atmosphere that promotes staff involvement. The approach that is best for the agency must be determined by the administrative staff. After the information has been collected, it must be carefully analyzed in order to determine training needs.

Once training needs are determined, the administrator must decide how to provide the indicated training. The best and least expensive resource for staff inservice training may be the staff itself...their strengths may be used to plan and facilitate workshops. If the indicated needs are ones that cannot be met within the program staff, it may be possible to have consultants come in to conduct training. If so, their credentials and past record of success in programs similar to that of the agency should be closely scrutinized. Once the consultant is contacted, a contract should be signed with him, listing the terms of the training

and any remuneration expected. Consultants, although thoroughly familiar with their topic area, may use professional terms that are unfamiliar to the participants. It should be stressed that layman terms be used whenever possible or that explanations of terms should be given. It is also helpful if a facilitator is present when a consultant speaks, to explain professional jargon to the participants and, if necessary, to ask the facilitator for concrete examples.

Determining the Level of the Workshop

If a consultant cannot be located in the community, it may be necessary to develop a workshop to meet specific needs within the program. It is of utmost importance to focus the workshop to meet the personal experience and training of the staff. The following questions should be considered: 1) Are the staff members professionally trained? 2) Are they certified? 3) Are they experienced in the field? 4) Do they keep their skills updated? If the personnel to be trained have little or no prior professional training, it may be necessary to use simple, non-professional terms and provide experiential activities; however, if the level of sophistication, experience in the field, and previous training are high, a very different type of workshop can be planned, with the group providing many of the solutions to the problem themselves through brainstorming and consensus reaching activities.

Refreshments

Refreshments are a necessary component of inservice workshops if the training is held during a working day. Staff members are often tired and need to renew their energy. Fresh fruits, nuts, and cheese are good choices of nutritional refreshments that will meet this need.

Determining Workshop Objectives

After deciding upon the level of the workshop, the decision must be reached as to what aspects of the issue need to be addressed in the workshop.

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Once isolated, these aspects become the objectives of the workshop; the points to be covered. The objectives should be written for the workshop participants...what the participants will learn from the workshop. For example, if it is determined that the staff needs inservice training in communicating with the children's families, you may wish to develop a workshop on communication. The objectives will be personalized to the needs within the program but may include such objectives as 1) To understand how to demonstrate interest through the use of body language, 2) To ask clarifying questions when necessary, 3) To make encouraging sounds to keep communication flowing, etc. The objectives should be written, refined, and as the content of the workshop itself is developed, refined further.

Outlining the Workshop

After the objectives are determined, the major topic should be considered. How should this topic be introduced? Is an icebreaker activity needed? (This often depends upon the level of sophistication of the participants and their familiarity with each other.) Icebreaker activities can be used not only to break down the natural reserve of the participants, but also to introduce the main focus of the workshop. The activity can introduce the primary focus of the workshop, then a general discussion can introduce new concepts and deliver new information. For example, if the topic of training is communication, the opening activity could center around an activity wherein communication among all the members is crucial. Perhaps a problem must be solved, like a scrambled sentence. Each member of the group might have one word of the sentence. The rules would state that the words may not be written down, only stated verbally. In order to unscramble the sentence, each member of the group must listen to the others and communicate his ideas to the group. After the problem is solved, the concept should be related to the main topic of the workshop; communication, and how

true communication requires both listening and speaking.

Throughout the workshop, the more participation one can draw from the participants, the better. It is important to remember that if the participants are actively involved in discussion and problem solving, they will benefit more from the workshop.

After new concepts are introduced, another activity should be included to give the participants an opportunity to use the material that has been presented. This activity may use one of several experiential approaches such as brainstorming, (the group volunteers ideas and the facilitator writes them down without comment) consensus building (the group breaks into two groups, with each group addressing a specific question that is actually one side of an issue. After a specified amount of time, the groups meet together, compare their lists of answers to the question and then find commonalities. For example, one set of participants might list the parenting skills needed to successfully parent the normally developing child and the other group might list the parenting skills needed by parents of children with special needs), vignettes (short scenarios), role plays, (the participants play specified parts), etc. This section of the workshop should not be rushed. Participants should be presented with an opportunity to share information with each other, solve problems together, and assimilate new concepts.

The last major component of the workshop is a summary of the material and concepts that have been covered in the workshop. One successful technique is to conclude the workshop with an assignment to give the participants an opportunity to individualize the information to their own situation.

Developing the Content

Once the objectives and outline of the workshop

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have been determined, the major portion of the work has been completed. All pertinent information must be included in the body of the workshop. If the facilitator is not familiar with the rationale behind the need for the training, it may be invaluable to include a Background Information section in the workshop content.

If possible, prepare handouts to cover major points of the workshop. These handouts may be used as resources by the participants. The use of a chalkboard or flipchart during the workshop facilitates learning for visual learners in the group and strengthens discussions. A list of the materials that the facilitator will need in order to successfully conduct the workshop should be included in the general format of the workshop.

Facilitating the Workshop

The facilitator should be thoroughly familiar with the content of the workshop. (Many facilitators highlight sections that they consider to be important.) All materials should be gathered before the workshop begins. Handouts should be duplicated and well organized. It is important for the facilitator to realize as the workshop begins that it is not necessary for her to talk all the time. The more other people are involved, the more successful the workshop will be.

The facilitator should listen carefully to other people's input and respond accordingly. If necessary, she should paraphrase what the speaker says. She may need to repeat what is said if other people have had difficulty in hearing or in understanding the speaker. If she paraphrases, she should ask the speaker if she has interpreted him correctly. If the activity calls for the group to divide into smaller groups, the facilitator should move from group to group, and remain actively involved.

Whenever possible, the facilitator should write the participants' contributions on the chalkboard

or flipchart. It gives value to what has been said. If the facilitator is facilitating a meeting of people who do not know her, she should not hesitate to use an anecdote to reveal that she has experienced similar problems and understands the difficulties that the participants are experiencing.

A good facilitator is sensitive, has good interpersonal skills, has a sense of humor, and is knowledgeable about the field.



EVALUATION OF WORKSHOP

These questions are designed to give the trainer feedback as to the quality of the workshop. Your assistance in completing this form will help to modify and improve content and method presentation.

Today's date: _____ Workshop Title: _____

Trainer: _____

Overall the workshop was: __ Excellent __ Good __ Fair __ Poor

Content of Workshop:

	<u>Strongly</u> <u>Disagree</u>	<u>Mildly</u> <u>Disagree</u>	<u>Mildly</u> <u>Agree</u>	<u>Strongly</u> <u>Agree</u>
1. I feel the information presented in this workshop will help me in my work.	1	2	3	4
2. The methods (group experiences, worksheets, role play, lecture, brain storming) used during this workshop were helpful for increasing my knowledge and understanding of the material.		2	3	4
3. The trainer presented material in a clear, concise manner.	1	2	3	4
4. The trainer encouraged questions and answered them sufficiently.	1	2	3	4

Overall:

1. What did you like the best about the workshop?

2. What did you like the least about the workshop?

3. What additional training do you feel you need in order to implement suggested procedures?

4. Additional Comments:

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WORKSHOP I: ORGANIZATION IDENTIFYING CHILDREN WITH SPECIAL NEEDS

Objectives:

1. To understand reasons for early identification and referral of children with possible special needs.
2. To learn methods for identifying children who need follow-up (observing, getting background information, screening).
3. To learn common "red flags" that may indicate the need for referral.
4. To learn how to sensitively communicate concerns to parents.
5. To learn the process of referral and what referral sources are available.

Materials:

1. Pencils and paper
2. Chalkboard or flipchart
3. Chalk or marker
4. Sample case study cards or overheads
5. Overhead projector and screen (optional).

Handouts and Worksheets:

1. What are Special Needs?
2. Examples of Gross Disorders that Suggest Need for Immediate Attention
3. Certificate of Child Health Examination
4. Informal Observations
5. Charts of Normal Development
6. Talking to Parents About Concerns
7. Referral Sources
8. Evaluation of Workshop forms

Preparation:

1. Reproduce enough of the handouts for each participant to have a set.
2. Prepare case study cards or overheads
3. Prepare handout on "Referral Sources" specific to the area (see handout "Referral Sources").

Background Information:

Many children with unidentified special needs attend day care centers and homes. If approximately 10-12% of the population have handicapping conditions requiring special services, then in a group of 20 children, 2 might need special services of some kind. Day care providers are in an excellent position to identify children who may have special needs because they see the child daily and may have other children the same age to use for comparison. An awareness of "red flags" that may indicate problems is critical. Caregivers are usually good identifiers, but need information on how to discuss concerns with parents and where and how to refer children for further evaluation. The presenter is also encouraged to refer to the modules in this manual for additional information on identifying and referring children with a specific type of need.

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WORKSHOP I: OUTLINE IDENTIFYING CHILDREN WITH SPECIAL NEEDS

NOTES

I. HANDICAPPING CONDITIONS

A. Warm-up Activity/Discussion

1. Ask participants questions such as:

- a. Have you ever worked with a child with a handicapping condition?
- b. If so, what kinds? (Write specific answers on the board or flip chart)
- c. Have you ever worked with a child that you **thought** had a special need, but was not identified?
- d. Why?
- e. What happened?

2. Go over the definition of "special needs" as listed in the Illinois Department of Children and Family Services Licensing Standards for Day Care Centers. List these categories on the board, flip chart, or overhead as they are discussed:

- a. visual impairment
- b. hearing impairment
- c. physical impairment
- d. health impairment
- e. speech and/or language impairment
- f. learning disability
- g. behavioral disability
- h. mental impairment

3. Use the suggestions made by participants as examples. Give others that they may not think of. Remind participants that impairments can range from very mild to severe and profound.

4. Discuss the term "handicapping". Explain that it comes from a word that means "cap in hand". Help participants to come to the awareness that what makes a condition "handicapping" is how it affects the child's daily life and/or learning.

II. THE IDENTIFICATION PROCESS

A. Purpose

1. Explain to participants that early identification is important so that children can be provided with services to reduce the impact of a potentially handicapping condition, or to prevent the condition from getting worse.

B. General Information

1. Typical Development—in order to identify atypical development, caregivers need to know what "typical" development is. Caregivers can be referred to the handout "Charts of Normal Development" or any other developmental charts. Caregivers should be encouraged to feel confident about their own abilities to identify children whose development is out of the ordinary. Most caregivers have personal

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experience with many children of a particular age and so have a basis for comparison that many parents don't have. It is, however, quite common for a caregiver to think the youngest in a group is delayed or a problem. It is also common for a child who is bored or unchallenged to become a behavior problem. In this case, moving the child to an older age group or providing more interesting activities might be helpful.

2. "Cultural Differences"—A child may have differences in his home environment that could lead a caregiver to think he was delayed in a particular area. Examples of this include the "street smart" child who is considered a behavior problem, or a child who speaks a form of non-standard English may be identified with a speech/language delay.

3. Misdiagnosed Handicaps—Sometimes one handicapping condition can be mistaken for another. Caregivers should be aware of this possibility and not be afraid to speak up if they think this has occurred. An example of this is when a hearing impairment is diagnosed as mental retardation. Luckily, mistakes such as these are quite rare now that vision and hearing are routinely screened when referrals are made.

C. "Red Flags"

1. Define the term "red flags"—There are certain things to look for in children that signal to us that a closer look may be needed. We call these signals "red flags".

2. Distribute the handout "Gross Disorders that Indicate Immediate Professional Attention". Go over some of the signals on the handout. Overheads or placards could be prepared that deal with specific areas listed on the handout. The facilitator could go over one of the areas in depth and encourage participants to study the remaining areas on their own. If there is enough time, going over the entire handout would be very useful.

D. Methods for Identifying Red Flags

1. Obtaining background information—Three methods of obtaining background information include health histories, parent questionnaires or checklists, and parent interviews.

a. Health histories can be obtained in written form or by interview. All licensed day care centers and homes must have an up to date physical form for each child enrolled (see handout "Certificate of Child Health Examination"). On this form is a section called "Medical History". This asks the parent for some very basic background information. Some providers may wish to develop a more complete health history form that includes such information related to pregnancy and child-birth such as whether the child was premature or spent time in a neonatal intensive care unit.

b. Parent questionnaires or check lists can give providers an idea of the parents' perceptions of the child's abilities. Questions such as "how many words does your child use at home?" can help providers to compare their observations with those of the parents.

c. Interviews with parents at a pre-enrollment conference can address many of the same questions as health histories or parent questionnaires. Parents can also be informed if children in the program will receive any kind of screening or follow-up services.

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ACTIVITY: Divide participants into three groups. Have one group develop a health history form, one a parent questionnaire or check list, and one a parent interview guide. It will be most helpful if participants who work in the same program work together. The groups should develop these information gathering tools based on the needs of their own programs or age groups. If the group is small, the entire group could work together on one.

NOTES

2. Observation—Participants should be encouraged to use both formal and informal observation methods. Informal methods include anecdotal records, collecting work samples, and observing the child's general appearance. See the handout entitled "Informal Observations" that is included at the end of this section. Formal observation methods include tape recordings or videos, frequency charts, time samplings, checklists, etc. It is sometimes helpful if another staff member observes the child to help a provider to check out her own perceptions of the child.

3. Screening

a. Explain the process of screening to participants. Screening is a process that identifies children who need to be referred for further evaluation or study for the purpose of identifying a possible handicapping condition, so that intervention or treatment can begin. Screening tests are inexpensive, quick, easily administered, and give a quick overview of the child's performance. They are normative, which means that they compare children of the same age/sex etc. A child may fail a screening test and have no special needs, and a child who does have special needs can pass a screening test.

b. Some types of screening tests include vision screenings, hearing screenings, and general developmental screenings. All programs serving young children should have these screenings done with all children. The public school usually goes through this process with older children.

III. REFERRAL: IF IN DOUBT, REFER!

A. Why Referral is Better

1. If no handicapping condition is found, no real harm is done.
2. If a child is not diagnosed, his special needs will probably not be met.
3. A child can be misdiagnosed.
4. You can have a child re-screened if you are unsure

B. Determining Appropriate Referral Sources

1. Distribute the list of referral sources particular to the area. A sample is included in the handouts section for your information. This list should be reviewed briefly to allow for questions.

ACTIVITY: Prepare a set of mini case studies of children with special red flags. Divide participants into groups. The groups are to use their red flags and referral sources lists to determine the appropriate referral

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source or sources. When participants have completed the task, have them come back together and discuss them as a whole. This activity will help participants to clear up any misconceptions.

C. Talking to Parents

1. This is the area that caregivers have the most concerns about. Discuss the suggestions provided in the handout "Talking to Parents About Concerns".

ACTIVITY: Role play a discussion between a parent and a caregiver in which the caregiver expresses her concerns about a child's development. When the role play is over, discuss with the group. This activity can also be done in small groups.

D. Making the Referral:

1. Discuss confidentiality and the fact that caregivers must have parental permission before making a referral. Sample RELEASE OF INFORMATION forms are included in the procedures section of this manual. Each agency takes referrals in their own way. If you are not sure of what to do, try using the telephone. Most agencies or schools will take referrals over the phone, and if they won't, they could send you needed information or forms.

IV. SUMMARY

Reiterate the reason for identifying possible handicapping conditions at the earliest possible time. Ask participants to list three pieces of information they learned at the workshop. In a small group, participants can take turns telling one thing from their lists. In a large group, call on as many people as you have time for.

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**GROSS DISORDERS:
EXAMPLES THAT SUGGEST THE NEED FOR
IMMEDIATE PROFESSIONAL ATTENTION**

SEEING

1. Red eyes, crusty eyelids or discharge from the eyes
2. Turning in or out of an eye or eyes (either permanent or temporary)
3. Squinting while looking at a near or far point
4. Unusual sensitivity to light
5. Excessive rubbing of eyes
6. Difficulty in seeing the board of working at close range
7. Bumping into objects or general problems with orientation and mobility
8. Lack of spontaneous response of the pupil of the eye to brightness or darkness
9. Leaning either to the right or left while working on an activity
10. Pushing a finger, hand, or object against the corner of an eye when trying to read
11. Lack of apparent response to peripheral stimuli
12. Excessive blinking, tearing or pain when opening and closing eyelids

HEARING

1. Low tolerance for noise or changes in usual patterns of sound
2. Requesting that an order be repeated, that radio or television volume be turned up beyond a reasonable level, or ignoring a direction
3. Showing no startle in situation that would normally result in some such response pattern
4. Discharge from the ears
5. Complaining of a buzzing or ringing in an ear
6. Turning head in one direction as if attempting to locate or tune in on a sound
7. Rubbing ears

MOTOR

1. Limping or showing difficulty in extending extremities
2. Exhibiting swollen joints
3. Getting fatigued while walking, running, or engaging in a normal amount of exercise for children of the same age
4. Seeming to bend or veer to one side while walking
5. Favoring one side of the body to a relatively extreme degree

EXAMPLES OF GROSS DISORDERS
PAGE 2

6. Having unusual trouble grasping and/or holding objects
7. Having pain in an extremity or in the back while walking or bending

PERSONAL/SOCIAL

1. Seeming to have a low threshold or tolerance for frustration
2. Having excessive trouble in socializing with people
3. Throwing toys or other objects whenever thing do not go the child's way
4. Yelling, shouting or cursing to excess at other people
5. Seeming to enjoy being alone most of the time; not apparently interested in being with children of own age
6. Exhibiting unusual behavior patterns such as whirling hands, butting head against objects, rocking body back and forth, eating unusual things, or picking a certain parts of the body
7. Giving verbal responses that appear excessively disconnected from personal surroundings or from reality
8. Crying at inappropriate times or in unstressed situations

SPEECH AND LANGUAGE

1. Making sounds that are so unclear, in contrast to those of other children of same age, that the listener cannot understand what is being said
2. Exhibiting excessive nasality, stuttering, hoarseness, speaking too high or low in pitch, or hesitating in speech
3. Pointing at an object when making a request instead of speaking
4. Seeming to have problems in understanding what is being said or in following directions
5. Choosing not to respond to a question or to speak spontaneously at a level usually characteristic of peers

GENERAL AREAS OF FUNCTIONING

1. Being active or inactive at inappropriate times or to an excessive degree
2. Coughing, wheezing, or exhibiting other similar types of characteristics that suggest possible health problem
3. Being absent from school on a continuing basis
4. Having constant problems keeping up with classmates in physical activities

1/30/90 msh

INFORMAL OBSERVATIONS

1. How does the child grasp objects? Is the grasp firm or weak?
2. Has the child established eye, foot, hand dominance?
3. If the child has a physical handicap does s/he compensate with other body parts?
4. Does the child explore the environment? If so, how?
5. What interactions occur between parent and child, child and peers, child and objects or materials, child and teaching staff?
6. Does the child establish eye contact?
7. What is the child's reaction to physical contact?
8. How does the child express emotions such as fear, anger, frustration, sadness, contentment?
9. Can the child follow directions?
10. At what level of play does the child operate (solitary, on-looker, parallel, associative, co-operative)?
11. How does the child transition between activities?
12. What tasks maintain attention?
13. How long is the child's attention span for various activities?
14. Are there things which create distractions?
15. How does the child problem solve?
16. What is the child's frustration level? What does the child do when frustrated?
17. What reinforces the child?
18. How often must the child be reinforced?
19. What is the length of response time once direction has been given?
20. Does the child comply with requests? What must be done to achieve compliance?
21. Does the child complete tasks?
22. What are the child's preferred activities?

23. When does the child perform best?
24. How does the child communicate? With body language? Gestures? Facial expressions? Words?
25. Does the child respond to voice tone?
26. What is the average length of the child's sentences?
27. Can the child ask, answer, and respond to questions?
28. Does the child use plurals, pronouns, present and past tenses?
29. How large is the child's vocabulary?
30. Does the child learn best by seeing, hearing, manipulating or combination of these?

TALKING TO PARENTS ABOUT CONCERNS

1. **Make parent(s) comfortable**--Make sure that the atmosphere is calm, quiet, and unhurried. Do not catch a parent at the end of a day when they may be in a hurry. Plan a conference time if possible.
2. **Be prepared**--Know important information about the child. Read over any notes or other information you may have. Be professional. Have objective information.
3. **Think developmentally**--Talk about the child now and what the next steps are.
4. **Be sensitive yet objective**--You are not helping anyone if you withhold necessary information.
5. **Ask leading questions**--"How does Joshua react in this situation at home?", "How does he compare with your other children?" etc.
6. **Use "I" statements**--"I have a concern in this area.", "I need some help with this.", "I would like to have some additional information."
7. **Use reflective listening**--"You're feeling unsure about this.", "You sound relieved."
8. **Know what to do next**--Explore referral sources. Know where to go to get more help.

PARENT CHECKLIST TO ASSESS DEVELOPMENT OF YOUNG CHILDREN

This is a checklist to help parents assess their young child's development. Listed are some activities and the usual age that the child performs that activity. There is also a column for you to record the age your child begins doing the activity. Remember, every child develops differently, the ages give are part of a range. This means that the majority of children usually do the activity at about that age. It does not mean that this is the age that every child must be doing it.

If your child is not doing an item at the given age, it is probably of no concern. However, if your child appears late in many items, please discuss his/her development with your doctor. If your child was born prematurely, it is important to subtract the length of his/her prematurity from the child's age. Example: A 10 month old infant who was born 2 months early is comparable to an 8 month old (10 months - 2 months).

ACTIVITIES	USUAL AGE	YOUR CHILD
1. Startles to loud noises 2. Looks at your face when in direct line of vision 3. Moves arms and legs energetically	1 month	1. 2. 3.
4. Moves head side to side while on stomach 5. Becomes quiet in response to adult 6. Maintains eye contact	2 months	1. 2. 3.
7. Follows face or object from side to side 8. Responds to noise with an eye blink 9. Smiles in response to adult talk and touch	3 months	1. 2. 3.
10. Raises head while on stomach 11. Holds a toy 12. Coos	4 months	1. 2. 3.
13. Reaches for an object 14. Watches hands 15. Recognizes bottle	5 months	1. 2. 3.

16. Sits with head erect when held 17. Plays using hands 18. Laughs	6 months	1. 2. 3.
19. Rolls from front to back and back to front 20. Reaches, grasps and holds with 1 or 2 hands 21. Turns to sound on either side	7 months	1. 2. 3.
22. Searches for dropped object 23. Distinguishes strangers from familiar persons 24. Turns $\frac{1}{4}$ circle while on stomach	8 months	1. 2. 3.
25. Grasps small object with whole hand (except thumb) 26. Vocalizes to gain adult attention 27. Places bottle in own mouth	9 months	1. 2. 3.
28. Imitates familiar sounds (dada, baba) 29. Moves to get a toy 30. Places objects (block) in container	10 months	1. 2. 3.
31. Imitates familiar actions (waves bye-bye) 32. Turns head to anticipate path of moving toy 33. Feeds self with fingers	11 months	1. 2. 3.
34. Uses precise thumb-finger grasp 35. Responds to name by looking 36. Holds out arms and legs on request for dressing and undressing	12 months	1. 2. 3.
37. Pulls to stand 38. Vocalizes word like sounds 39. Gives objects when asked	13 months	1. 2. 3.
40. Walks 41. Names 5 familiar objects (dog, ball) 42. Fits boxes or cups inside each other	18 months	1. 2. 3.

43. Walks up and down steps 44. Scribbles with crayon 45. Understands "yours" and "mine"	2 years	1. 2. 3.
46. Names familiar pictures (cat, dog) 47. Throws ball underhand 48. Plays along side another child 49. Uses "in" and "on" correctly	3 years	1. 2. 3. 4.
50. Hops 51. Draws simple design (circle) 52. Plays with friends 53. Asks questions	48 months 4 years	1. 2. 3. 4.
54. Predicts common "next" events 55. Skips 56. Uses "he" and "she" correctly 57. Draws "pictures"	60 months 5 years	1. 2. 3. 4.

DEVELOPMENTAL MILESTONES AGES 6 - 12

AGE 6-

- can ride a two wheel bike
- can roller skate
- can tie shoes
- can spread butter with a knife
- can run backward a few feet
- knows right from left

AGE 7-

- can cut meat with a knife and fork (not well)
- can comb own hair
- counts by twos and fives
- repeats five numbers forward and three backward
- can tell time
- follows a line on a maze
- balances on toes while bending forward at the waist

AGE 8-

- can write cursive
- touches each finger to all other fingers
- can count backward from 20
- can give the right change for a dollar
- can stand on one foot for ten seconds

AGE 9-

- can skim a book
- can multiply and divide
- can join cursive letters neatly
- judges weights in order of their heaviness
- can stand on one foot with eyes closed

AGE 10-

- can skip double dutch
- can do complex fine motor manipulations (build models, do crafts)
- can jump while clapping hands three times
- repeats a 20 syllable sentence
- understands numbers greater than 100
- balances on tip toes with eyes closed

AGES 11 & 12-

- can catch a ball with one hand
- can jump up and touch their heels with both hands
- can reproduce a geometric figure from memory
- can wash a car or do other chores on that level
- can stand on one foot with sole of other foot pressed against that leg like a stork.

REFERRAL SOURCES FOR CHILDREN IN CHAMPAIGN AND FORD COUNTIES

GENERAL DEVELOPMENTAL CONCERNS:

The following programs serve children with a wide variety of special needs. In most cases, one of these would be the best to call for any concerns you might have. These programs can also refer you to other sources..

Developmental Services Center Children's Services (for children up to age 3)	1304 W. Bradley Avenue Champaign, IL 61821	359-0287
Champaign Unit IV Schools Marquette School (for children 3-5 in Champaign city limits)	405 E. Clark Street Champaign, IL 61820	351-3881
Urbana Unit 116 Schools Washington School (for children 3-5 in Urbana city limits)	1102 North Broadway Urbana, IL 61801	384-3513 or 384-3616
Spectrum Early Childhood Program Colonel Wolfe School (for children 3-5 in rural Champaign County)	405 East Healey Urbana, IL 61801	333-4890
Ford-Iroquois County Special Education Association (children in Ford County)	108 E. Front Street Gilman, IL 60938	815/265-8601

CONCERNS ABOUT HEARING:

Parents should contact the child's regular physician when there is a concern about hearing. The regular physician may refer the child to an ear, nose, and throat (ENT) doctor or otolaryngologist if needed. The ENT will examine the ears and refer the child for further evaluation if indicated. Often the child's regular doctor will refer the child to this specialist. Other referral sources include:

Central Association for Special Education (C.A.S.E.) (audiological evaluations at no charge to families in both Champaign and Ford Counties)	51 Gerty Drive	333-7023
Champaign-Urbana Public Health (hearing screening no cost) at day care centers for children over age 3 and in the clinic on Tuesday mornings for children below age 3)	710 North Neil Champaign, IL 61820	352-7961
Hearing Education Program Christie Clinic (will conduct outreach screenings at no cost for children below age 3 in both Champaign and Ford Counties)	101 W. University Ave. Champaign, IL 61820	351-9669

VISION CONCERNS:

Most children in public schools are screened for vision in kindergarten, third, and fifth grades. Parents can be referred to an optometrist or ophthalmologist for hearing testing depending on the age of child and the complication of the problem.

Champaign-Urbana Public Health	710 North Neil Champaign, IL 61820	352-7961
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(vision screening can be done at day care centers for children ages 3 and up and in the clinic on the first Tuesday mornings of the month for children who live in Champaign or Urbana)

Central Association for Special Education (C.A.S.E.)	51 Gerty Drive	333-7023
<i>(vision screenings at no charge to families for children in both Champaign and Ford Counties)</i>		

MOTOR/PHYSICAL CONCERNS:

Parents should be encouraged to discuss concerns in the motor or physical area with the child's physician. Physicians must give permission for occupational or physical therapy evaluations. Refer also to the sources listed under General Developmental Concerns.

SPEECH/LANGUAGE CONCERNS:

Sources listed under General Developmental Concerns are also appropriate for concerns in the speech/language area. Another referral source is:

University of Illinois Speech and Hearing Clinic	901 S. Sixth St. Champaign, IL 61820	333-2230
<i>(serves children and adults of all ages for screening, evaluation, and treatment on a sliding fee scale)</i>		

HEALTH CONCERNS:

Health concerns should be addressed by the child's physician. A child may need to be seen by a specialist for concerns in specialized areas. Local public health departments are listed below.

Ford-Iroquois Public Health Dept.	B-10 Courthouse Paxton, IL 60957	379-2523
Champaign-Urbana Public Health	710 North Neil Champaign, IL 61820	352-7961
Francis Nelson Health Center	1306 N. Carver Champaign, IL 61820	356-1558

SOCIAL/EMOTIONAL/BEHAVIORAL CONCERNS:

CHILD ABUSE HOTLINE

1-800-25-ABUSE

Champaign County Mental Health Ctr. Child Adolescent Program	600 E. Park St. Champaign, IL 61820	351-8811
University of Illinois Psychological Clinic	505 E. Green Champaign, IL 61820	333-0041
Dept. of Children & Family Services	508 S. Race St. Urbana, IL 61801	333-1034
Parents' Anonymous Children's Home & Aid Society of IL	1819 S. Neil St., Suite D. Champaign, IL 61820	359-8815
Community Resource & Counseling Ctr.	Pine St. & Route 45 Paxton, IL 60957	379-4302

Section IV - Workshop Series Outlines

WORKSHOP II: ORGANIZATION INTRODUCTION TO HANDICAPPING CONDITIONS

Objectives:

1. Participants will learn the difference between a handicap and a disability.
2. Participants will explore their own reactions to being handicapped.
3. Participants will learn the advantages of integration for children and adults.

Materials:

1. flip chart or chalkboard
2. markers and/or chalk
3. materials needed for experience stations
4. 5 large pieces of newsprint
5. masking tape

Preparation:

Facilitator should choose activities and prepare experience "stations" around the room where participants can "try on" a variety of handicaps. The number and type of stations will depend on group size and needs. Specific materials and directions for setting up stations are included at the end of this section. Some activities can be done with the whole group. If these are done first, participants can get an idea of how the experience stations can be approached. Place large sheets of newsprint with the numbers 1,2,3,4, and 5 on the walls around the room. These will be for the final activity.

Facilitator should write the following quote on the board or have it prepared on a flipchart or overhead and leave it up during the workshop:

"WE CANNOT HELP UNTIL WE UNDERSTAND
WE CANNOT UNDERSTAND UNTIL WE FEEL
WE CANNOT FEEL UNTIL WE BECOME."

Background Information:

One of the most important predictors of success in mainstreaming or integration is teacher attitude. If a teacher or caregiver believes that a child can be successfully integrated, she is more likely to work toward that goal. If she has a positive and accepting attitude toward children with special needs, the child will feel more comfortable. Caregivers convey their attitudes to the OTHER children as well. If the caregiver doesn't truly accept the child(ren) with special needs, neither will the other children.

If a caregiver believes that ALL children deserve quality care, and that there are advantages to serving children with special needs together with children who are developing normally, the integrated setting can be a positive experience for all involved.

This workshop is based on the premise that experience is the best teacher. Caregivers will be given the opportunity to "try on" a variety of handicaps and then perform some simple tasks. It is hoped that this experience will help participants become more aware of how it feels to have a disability and that children with disabilities are first and foremost children.

Section IV - Workshop Series Outlines

NOTES

WORKSHOP II: OUTLINE INTRODUCTION TO HANDICAPPING CONDITIONS

I. INTRODUCTION

A. Warm-up Activity

Have participants choose a partner. Each partner should tell the other what she did this weekend **WITHOUT USING WORDS**. Sign language is allowed but writing and drawing are not. At no time is either partner allowed to talk. This means that participants cannot "check out" what the other person is saying. Allow 5-10 minutes for this part of the activity. Then have caregivers go around and tell the rest of the group what their partner told them. Only now can partners correct mistakes or let each other know if a sign or gesture was misinterpreted. Encourage participants to discuss how they felt during this activity.

B. Definition

Handicapped children have disabilities in one or more areas affecting their ability to learn or develop at the same rate as others of the same age--their abilities, however, may not be affected in ALL areas. Some handicaps are more obvious: severe cerebral palsy, Down Syndrome, deafness, blindness, etc. Severe and obvious handicaps are not very frequent, but mild to moderate handicaps are more common.

II. WHO ARE CHILDREN WITH SPECIAL NEEDS OR HANDICAPPING CONDITIONS?

A. First and most important, children with special needs are just children. They are more like other children than they are different.

B. The handicapping condition is only one aspect of the child's total picture of strengths and weaknesses.

C. 10-12% of all children have some kind of handicapping condition.

III. SERVING CHILDREN WITH SPECIAL NEEDS IN INTEGRATED SETTINGS

A. Advantages to Children with Special Needs

1. Normally developing children can serve as models
2. Independence is encouraged
3. Normalized life style
4. Children are encouraged to strive for greater achievements

B. Advantages to Children Who are Normally Developing

1. Children learn to accept and be comfortable with individual differences
2. Attitudes become more positive when normally developing and children with handicaps play together regularly.
3. Self concept and the spirit of helping are promoted.

Section IV - Workshop Series Outlines

C. Advantages to Caregivers

1. Gives them the chance to make an impact on a child with a handicapping condition
2. Enables them to learn techniques that can be just as useful for nonhandicapped children
3. Broadens the caregiver's personal and child care experience

NOTES

IV. EXPERIENTIAL LEARNING

A. A Whole Group Experience

1. If possible, obtain a copy of "The Unfair Hearing Test" which is available from the Council for Exceptional Children (see references) in their training manual entitled "Everybody Counts". In this exercise, participants are asked to listen as a list of words is read in a manner which simulates a mild high frequency hearing loss. Listeners are told to write down what they THINK they hear. This activity is a wonderful vehicle for promoting understanding of mild hearing loss such as occurs in children with conductive hearing problems caused by ear infections.

B. Learning Stations

1. Explain each of the stations to participants. Encourage them to try each activity as they see fit. They may want to work in pairs. The facilitator should circulate among the stations answering questions and raising issues for participants to discuss or think about. Be prepared for a great deal of laughter!

C. Discussion of Experiences

1. After participants have had a chance to try out all the activities, have them come together as a group again. Go over the quote that has been on the flipchart throughout the workshop. Encourage participants to reflect upon their experiences and to discuss the meaning of this quote.

D. Closing Activity

1. The facilitator should have placed the numbers 1-5 on large pieces of newsprint around the room. Tell the participants that they should get up and stand behind each number that represents their own abilities or disabilities:

- a. If you wear glasses, stand by number 1.
- b. If you are left-handed, stand behind number 2.
- c. If you cannot turn a cartwheel, stand behind number 3.
- d. If you cannot drive a stick shift, stand behind number 4.
- e. If you cannot type 60 words a minute, stand behind number 5.

V. SUMMARY

Have participants develop a definition for the word handicapped. Participants should come up with the idea that we all have things we can't do but they only become handicaps when they keep us from participating in normal activities with our peers.

DISABILITY ≠ HANDICAP

MATERIALS FOR SIMULATION OF HANDICAPPING CONDITIONS

Collect and prepare the following materials for Activity 1 simulations. Typed instructions to cut apart and place with the materials follow.

1. VISUAL (tunnel vision)

Materials: Glasses or mask with all areas blocked out except for small hold in center of eye area

Typed copy for reading (story, paragraph or other informatoin typed across 11" of page).

Instruction Card: Put on the mask (glasses).
Unfold the paper.
Read the story without moving yourhead.

Alternate

Instruction Card: Put on the mask.
Look at your partner.
Describe what is happening on the left
and right sides of the room.

2. VISUAL (patched eye, amblyopia)

Materials: Glasses or mask with right eye space completely blocked out or eye patch.

Instruction Card: Put on the mask.
Look at your partner.
Describe what is happening on the right
side of the room. Without moving your
head, move sideways to the left and to
the right.

3. VISUAL (distored or low vision)

Materials: Glasses with rubber cement on lens for distortion;
color book and crayons

Instruction Card: Put on your glasses.
Select a picture to color.
Stay in the lines as you color.

4. VISUAL (color distortion)

Materials: Dark glasses (such as those given out by optometrists
after eyes have been dilated.) 6 inch cubes (3 dark blue,
3 purple) in a sack or box.

Instruction Card: Put on the glasses.
Take out the blocks one at a time.
Name the colors you hand each block to
your partner.
How many colors did you name correctly?
P.S. Don't peek at the blocks first.

5. VISUAL (low or distorted vision)

Materials: Glasses or swim goggles painted with rubber cement
for distortion; magazine article with lots of type and small
print

Instruction Card: Put on the glasses.
Read this article and explain it to your
partner. Look around the room. Can you
describe what is happening?

6. FINE MOTOR (hand movement and control)

Materials: Oven mitt or glove with fingers glued together;
box of colored pegs (or other activity requiring finger-thumb
precision)

Instruction Card: Put the glove on your dominant hand.
Do not use your other hand.
Open the box of pegs.
Put all the red pegs in the box lid.
Do not spill the pegs.

7. MOTOR (wrist, hand movement)

Materials: Arm weight; pencil and paper; typed story to
copy

Instruction Card: Put the weight on your wrist.
Copy the story. Do it quickly.

8. MOTOR (hand movements, coordination)

Materials: Pair of work gloves with fingers glued together;
large shirt or pajama top; large pair of jeans. (If you
cannot borrow a large shirt and jeans, try your local Goodwill
store)

Instruction Card: Put on the gloves.
Put on the shirt and button it.
Hurry, it's time for school!

9. MOTOR (gross movement)

Materials: Leg weight

Instruction Card: Put the weight on your ankle.
Skip to the door and back.

10. MOTOR (gross movement)

Materials: Rope

Instruction Card: Tie your knees together.
Walk across the room.
Try running.
Now hop and jump.

11. SLOW LEARNING (timed task, too difficult to complete)

Materials: Egg timer; page of difficult arithmetic problems;
pencils

Instruction Card: Work these problems in 3 minutes.
Use the egg timer to time yourself.
Work quickly.
Stop when the time runs out.

12. LEARNING (visual perceptual)

Materials: Mirror; 3x5 cards or paper; pencils

Instruction Card: Look in the mirror as you write your
name, address, and telephone number on
the card. Now write the following sentence
"Poppy, Daddy, and Bubba went to visit
Grandmother Doublequip and took their
puppy."

Will you earn an "A" for penmanship?
Did you have to think about writing the
letters p, b, and d?

13. LEARNING (visual perceptual)

Materials: Mirror, pencil, design to trace or maze to follow

Instruction Card: Look in the Mirror.
Complete the maze quickly.
Stay within the lines.
Do not look directly at the pattern.
Trace only while looking in the mirror.

14. LEARNING (visual perceptual)

Materials: Story typed in reverse. (Make this by typing
with carbon paper turned backward or the wrong way. This
will print reverse.)

Instruction Card: Read this story.
Write three facts about it.

15. SPEECH (mouth movements)

Materials: Wooden spoons, napkins, jar of thick peanut
butter

15. SPEECH (mouth movements)

Materials: Wooden spoons, napkins, jar of thick peanut butter

Instruction Card: Put of spoonful of peanut butter on the roof of your mouth.

Read aloud:

She sells sea sheels down by the seashore.

If she sells sea shells down by the seashore,
how many sea shells shall she sell?

Read it again, very quickly.

16. SPEECH (mouth movement)

Materials: Mouthpiece (such as used by football players); jar of alcohol or peroxide to clean mouthpiece; napkins

Instruction Card: Put mouthpiece in your mouth. Read the following tongue twister:
Sally sells sea shells down by the seashore.
If she sells sea shells down by the seashore,
how many sea shells shall Sally sell,
showing sea shells by the score?
Drink a glass of water.
Wear the mouthpiece while talking to others.

Section IV - Workshop Series Outlines

WORKSHOP III: ORGANIZATION COMMUNICATION SKILLS

Objectives:

1. To acknowledge the need to establish communication with parents and other professionals.
2. To understand that listening to the other person and attempting to understand what is said are the most important aspects of communication.
3. To understand how to use active listening techniques.
4. To understand how to respond to others.
5. To understand the use of body language in communication.
6. To avoid using professional jargon when communicating with parents.
7. To learn to clarify information by asking questions.

Materials:

1. Chalkboard or flipchart (marker or chalk)
2. Activity 1: Slips for relay race (Body Language)
3. Activity 2: Parallel Conversation Role Play
4. Activity 3: Closed Questions
5. Pencils and paper

Preparation:

1. Gather materials
2. Decide how you are going to break the participants into small groups.

Background Information:

Although most professionals who work with young children are experts at delivering information to others, they may not be skilled listeners...may not have expertise in how to read others' body language, how to listen to and interpret the speaker's tone of voice, how to use active listening in order to encourage the speaker to continue, nor understand how to ask clarifying questions. Many people have read the terms body language and active listening. In actual practice; however, they may not use communication skills effectively either in their interactions with parents or in their interactions with their fellow professionals.

This workshop is designed to help staff members become more aware of the need to use communication skills on a daily basis and to give them an opportunity to refresh those skills.

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WORKSHOP III: OUTLINE COMMUNICATION SKILLS

NOTES

I. COMMUNICATION

A. Activity

Icebreaker (Body Language Relay) This activity is a relay race. Divide the group into teams of 4-6. Give each person a slip of paper with an emotion on it. The first person in the line reads a slip telling her to display, say, anger. She acts it out, and the team guesses the emotion. The next person in the line names the emotion and in turn reads a slip that instructs her to portray shock, etc. The first team to finish wins the relay.

B. Discussion

Following the activity, the discussion should include the points, that in the activity, the team could win only if they were expert in reading the other person's body language. This also applies to real life. In order to understand other people and what they are attempting to communicate to you, you must be able to read their body language. However, reading others' body language is only one of the important skills that need to be developed in order to communicate effectively with parents and with other professionals. In order to best serve children, it is essential to communicate effectively with other people. This is going to be our topic today. We are going to discuss the skills involved in communication. It has been said that communication is the basis upon which any effective relationship must be built. Therefore, becoming skillful communicators will not only be beneficial to our professional lives, it will also enhance our personal lives.

II. INTRODUCTION OF NEW CONCEPTS:

A. Lecturette: Communication Skills

There are many important skills to develop in order to communicate effectively with other people. Most of us are very effective deliverers of information. We have learned through professional training and through experience to deliver information to other people both through the written word and the spoken word. We are very skilled at letting other people know what we think...the problem comes in understanding what the other person is saying to us.

Therefore, in order to establish this understanding, there are several skills that we need to develop. What do you think is the first thing that we need to do? WAIT FOR AN ANSWER. You're right! We need to learn to listen. WRITE LISTEN ON THE CHALKBOARD OR FLIPCHART. Most of us think that we already listen, but in actuality, many of us are so busy thinking of the next point that we want to make, that we really don't listen to what is being said. In order to really listen to the speaker, we must clear our heads of our own agenda. WRITE CLEAR HEADS OF OWN AGENDA ON CHALKBOARD OR FLIPCHART. As the speaker is talking, we need to look at her. What is her body telling us? (WRITE OBSERVE BODY LANGUAGE) We need to listen to the tone of voice...does it match the content of what is being said? (WRITE LISTEN TO TONE OF VOICE) and we may need to ask clarifying questions in order to understand the content of what the speaker is telling us. (WRITE ASK CLARIFYING QUESTIONS) Sometimes we also have to make some kind of an encouraging sound in order to get the speaker to continue. (WRITE MAKE ENCOURAGING SOUNDS). Let's discuss each of these points one at a time.

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1. Clear heads of own agenda.

ACTIVITY: This activity will be an example of a parallel conversation in which each speaker pursues her own agenda, with little or no indication of having heard what the other person is saying. Have two of the participants read the role play. Discuss. Were the two people in the role play really listening to each other or were they each following their own agenda? Did either one of them really communicate with the other? Have the participants ever heard this type of conversation? How could it be better? Go through the role play again. This time have only the first speaker read her lines. Have the second speaker ad lib a better response.

Discuss the difficulty of actually clearing your head of your own agenda. Discuss ways that this could be done while still accomplishing the points that the participant needs to make during the conference or conversation. Suggest making a list of points that need to be covered before the conference begins. Ask for suggestions. What have the participants found to be helpful?

2. Body Language:

a. We have all heard the term body language. Let's review the definition to be sure that we are all thinking of the same thing. Who can tell us what it means? **WRITE THE DEFINITION ON THE CHALKBOARD.** (One definition might be: "the way we communicate thoughts and feelings through our body positions and movements".) One study reported that message impact is only 7% verbal, (choice of words), 38% vocal (tone), and 55% body language (McGough, 1974) so it is essential that in order to establish effective communication that one of the skills we develop is the skill of reading others' body language.

b. Brainstorm ways in which others indicate their feelings to us through their body language. List all ideas on a flipchart or chalkboard. Be sure the discussion includes (1) signs of anger such as the way the arms may be crossed, (2) signs of impatience such as drumming of fingers on the table, tapping foot, swinging a crossed leg, (3) signs of rejections such as turning slightly away, pulling back, (4) facial expressions such as anger, tenseness, hurt, rejection. (5) signs of boredom such as doodling on paper.

c. Ask for a volunteer. Ask her to talk to you. As she talks, model the various forms of body language. Ask the participants to read what your body language is saying to the other person.

d. Ask why it might be important to learn to read others' body language. Ask for examples from the floor when the participants have noticed that someone to whom they were talking was displaying body language that might be contrary to what was actually being said. An example might be a parent whose child is hurting other children. You have to tell the parent and suggest ways that the behavior should be handled. As you talk, the parent seems to be agreeing with you, but you can tell by the way she is holding her arms, and tapping her foot, that she is really angry at what she probably interprets as an attack

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on her child.

3. Tone of voice

a. What do we mean by the tone of voice? If we listen carefully to the content of what is said, isn't that enough? Why is it important to learn to become skillful at interpreting the speaker's tone of voice? Model the following example: Say, "I think you are absolutely right. We'll do just what you say". Say this in an extremely controlled, angry voice with a tight smile on your face, looking off to the side, and with your arms crossed in a rejecting manner. Then ask the participants if they think you really meant what you were saying. Which clue really was most indicative of what the speaker meant, the content of what was said, or the tone of voice and body language?

4. Clarifying Questions

a. Ask what do we mean by clarifying questions? ALLOW TIME FOR DISCUSSION Discuss the different kinds of questions that could be used to clarify information. Discuss the difference between open questions (What types of activities does Johnny like to participate in at home?) closed questions (Does Johnny play ball at home?), and indirect questions (You have probably noticed many different activities that Johnny enjoys). Discuss the difference in the amount of information gained from each of the questions. Discuss the fact that each type of question has its place, but that people often become resentful and refuse to cooperate if too many closed questions are asked.

ACTIVITY: Have the participants break into their small groups. Give each group a closed question, have them change it first into an open question, then into an indirect question.

5. Active Listening

a. What is meant by the term "Active Listening"? Give examples of how it can be used skillfully. Discuss "Reflective Listening", (paraphrasing what the other person is saying to be sure you are interpreting correctly, for example, "I understand you to say that you think Johnny acts better at home than he does here, is that right?"), making encouraging sounds to get the other person to continue. (Examples: "Ummm, I see, Go on")

III. PROFESSIONAL JARGON

A. Discuss: Use of professional jargon.

Ask the group to generate a list of terms that might be misunderstood by others such as people in other fields, or primary care takers. WRITE THE LIST ON THE CHALKBOARD/FLIPCHART.

IV. USING THE SKILLS TO SOLVE PROBLEMS

ACTIVITY: Have the participants break into small groups. Each group will identify a problem that they have encountered professionally when

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communication has broken down. This can be a problem with either parents or other professionals. Give the participants 15 minutes to identify the problem, and think of a way that communication skills could have been used to improve the situation. Bring the groups back together for a general discussion with each group presenting their identified problem. Allow as much time as you have left for this discussion. This will be the most valuable part of the workshop to the participants as they work together to problem solve their identified problem.

V. SUMMARY

As we work together to provide programs for children, we must learn to communicate effectively not only with the child's primary care giver, but also with each other within this program and with professionals in other programs. It is vital, then that we learn to (RETURN TO ORIGINAL LIST OF POINTS TO BE COVERED (1) LISTEN, (2) CLEAR HEADS OF OUR OWN AGENDA, (3) OBSERVE BODY LANGUAGE, (4) LISTEN TO TONE OF VOICE, (5) ASK CLARIFYING QUESTIONS, AND (6) USE ACTIVE LISTENING.) These are all skills that will enable us not only to convey information to others but that will enable us to understand what the speaker is saying to us. These skills are very difficult to master. They require hard work and dedication in order to really master them. However, the benefits are worth the effort, because communication is the basis of all relationships.

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Emotions for Relay Race (copy as many times as needed)

ANGER

SHOCK

FEAR

HAPPINESS

SADNESS

SURPRISE

DISAPPOINTMENT

JEALOUSY

PRIDE

BOREDOM

CONFUSION

EMBARRASSMENT

SHAME

CLOSED QUESTIONS

1. Can Johnny talk?
2. Do you think you can do this?
3. Does Tamira have any trouble eating?
4. Do you have any toys Shawn can use?
5. Does Tory get along with the other children?
6. Can Calvin play baseball?
7. Do you know much about language development?
8. Do you work with parents or not?
9. Katie has a lot of problems, doesn't she?
10. Staff training workshops are a great idea aren't they?
11. Have you ever seen Jesse throw anything?
12. Do you think Sally is getting along with her teacher at school?

PARALLEL CONVERSATION ROLE PLAY

This is a conversation between Jan, an occupational therapist working with Dusty, and Kathy, Dusty's day care provider. This meeting was set up so that Jan and Kathy could discuss what Dusty has been doing in therapy and how this can be reinforced while he is in day care.

JAN: "Hello Kathy, my name is Jan Black and I'm the occupational therapist who is working with Dusty."

KATHY: "Hi, I'm so glad to meet you, Jan. I have so much to talk to you about."

JAN: "Great, I do too! I wanted to tell you about the goals we're working on in therapy."

KATHY: "Before you start, Jan, I have a question to ask you. How many children are in Dusty's class at school?"

JAN: "Well, the class is pretty full now, but I usually take one or two kids out every morning and so does the speech therapist and the physical therapist."

KATHY: "You know it's going to be really hard for me to work with Dusty at day care in the afternoon because I have so many other kids to take care of."

JAN: "It shouldn't be too bad. Some things Dusty really needs to work on are his balance and motor planning."

KATHY: "Well, we take a short rest time after lunch and the kids have to be quiet and not move around much then. We go outside around 2:30."

JAN: "Dusty is doing really well in therapy. He's made a lot of improvement since last spring."

KATHY: "Do you only see one child at a time for therapy?"

JAN: "Occupational therapists are doing more work with children while they're in the classroom now."

KATHY: "I have 20 kids in my room with just me and my aide, who's not very helpful. I don't think I have enough help."

JAN: "I'm sure you can help Dusty! He's a really easy kid to work with and he doesn't need much at this point."

KATHY: "I'm glad, because I wouldn't want the other kids to suffer because I have to work with Dusty. I already have so much planning to do."

JAN: "They won't, don't worry. Here's what to do (gives Kathy a three page list) and here's a book about Dusty's disability. I need it back next week, okay?"

KATHY: (Takes things)

JAN: "Well, it's time for me to see my next client. It was great to meet you in person, Kathy. I think we got a lot done today."

KATHY: "Yes (looks confused)."

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WORKSHOP IV: ORGANIZATION BEHAVIOR MANAGEMENT

Objectives:

1. To recognize the similarities in the behaviors of normally developing children and children with special needs.
2. To understand that all children need limits.
3. To understand that adults should exhibit expectations of all children, both normally developing children and children with special needs.
4. To understand appropriate behavior management strategies.
5. To develop plans for specific behavior problems.

Materials:

1. Warm-up Activity: Blurpland
2. Chalkboard or Flipchart
3. Chalk or Marker
4. Handouts and Worksheets:
 - Reinforcing Good Behaviors Worksheet
 - List of Preventive Techniques
 - Planning Ahead
 - Steps in Problem Solving
5. Table and chairs for Blurpland Activity
6. Napkins
7. Doughnut holes or cookies
8. Overhead Projector and screen (optional)
9. Pencils and paper

Preparation:

1. Reproduce enough of the handouts for each participant to have a set.
2. Gather the materials for the Blurpland Activity.
3. Set up the props for the Blurpland Activity.
4. Gather materials for other activities.
4. Set up the overhead projector (if desired) and the flipchart if a chalkboard isn't available.

Background Information:

Children with special needs are being identified more frequently and are being mainstreamed into settings that may not have previously provided services for them. Children with special needs are first and foremost children, with many of the same needs that all children have. They may progress at a different rate and have problems that require adjustments within the group, but their needs are basically the same as those of all children. Therefore in order to develop appropriate social and behavioral skills, adults working with them should set limits and exhibit expectations of them. The lack of appropriate social and/or behavioral skills is the most common reason that children with special needs are not maintained in an integrated setting.

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WORKSHOP IV: OUTLINE BEHAVIOR MANAGEMENT

I. GETTING ACQUAINTED

A. Warm-up Activity: Blurpland (Included at end of workshop.)

The purpose of this activity is to make adults aware of the way children feel about rules that they don't understand: rules that they don't know yet. The activity itself will be gone through twice. Once before the participants have heard the rules and once after they have been told the rules. They will see for themselves that it is much easier to act as others want you to act if you know the rules ahead of time.

II. INTRODUCTION TO KEY CONCEPTS

A. Child Behavior

Compare the behavior of normally developing children with that of children with special needs. Encourage discussion. Is the behavior necessarily different if the child's needs are different? Do the same strategies apply to children with special needs? Should the strategies be adapted in any way?

B. Adult Expectations

Should teachers have behavioral expectations of children with special needs? Discuss the differences. Emphasize the similarities.

III. MANAGING BEHAVIOR

Discuss what is meant by the term, managing behavior. Does this term have only negative connotations? Are there positive implications? Encourage discussion. State that in this workshop you are going to discuss several different aspects of managing behavior: how to prevent undesirable behaviors from emerging, how to increase desired behaviors, and how to decrease inappropriate behaviors.

A. Prevention

Discuss the five major strategies that may be used in order to prevent behavior problems from developing. These strategies include: (1) having a developmentally appropriate program that considers the needs and interests of the children as individuals; (2) modeling the behaviors you want the child to imitate; (3) letting the child learn from experience; (4) planning ahead; and (5) making your expectations of the child clear. As each of the five strategies are discussed, list them on the chalkboard/flipchart. As you list each strategy, ask the group to give examples. Add any of the examples that are listed in this workshop that may be omitted by the group.

1. Having a developmentally appropriate program

a. the setting is developed around the needs and developmental level of the children. The toys are appropriate, the furniture is the proper size.

b. the schedule meets the needs of the children. If the children are young, snacks and nap times are provided at regular intervals. If the

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children are school aged, snacks and rest times are carefully planned.

c. field trips and activities are planned that are developmentally appropriate.

d. having an appropriate balance of child-directed and teacher-directed activities.

2. Model desired behaviors:

Example: If you want children to exhibit quiet voices, speak quietly

Example: If you want children to be nonviolent, use disciplinary measures that are nonviolent. Discuss this with the group. What are violent disciplinary measures? What are examples of nonviolent disciplinary measures?

Example: If you want children to exhibit concern for others, show concern and understanding of their problems.

Example: If you want children to use good manners, do so yourself.

3. Let the child learn from experience. Ask for examples. What is meant by learning from experience? Should you let a child do something that you know will harm him? Stress the difference between learning from experience and logical consequences.

a. children can learn by suffering the natural consequences of their acts.

Example: If a child grabs a toy or refuses to share with other children, those children will not want to play with him.

Example: If an older child cheats when playing games, other children will refuse to play with him.

Example: If a child refuses to wear gloves his hands will be cold.

4. Plan ahead (relate to the opening activity)

a. plan activities to reduce boredom

Example: If a water table is set up daily for preschool children, it will soon lose its novelty and become boring. However if new activities are introduced, such as adding food coloring to the water, or simple beaters to make bubbles in the water, the water table will continue to retain the children's interest.

Example: Older children will become newly interested in building materials or art supplies, if they are introduced to a new country and are encouraged to recreate the architecture of the country or to make flags or other artifacts that are associated with the country. These children can become fascinated by attempting to build an Egyptian tomb or recreating a cave man's cave.

b. restructure time. Think through the time you have allotted for each activity throughout the day and the schedule you have set. Where do the problems exist? How could you change your schedule in order to better accommodate the needs of the children and prevent undesirable behavior?

Example: In centers or home care situations where preschool children are being cared for, it may be important to think about their schedules before they come to the care provider. Do they start their day around 5:30 or 6:00 a.m.? Have they been up for several hours by 10:00 a.m.? Perhaps the schedule needs to be adjusted by adding an early snack and nap.

Example: Elementary aged children who receive after school care may have had an exhausting day before they arrive at the care provider. They have been

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sitting for long periods of time and may need nothing as much as they need to run and shout. Other children may need time alone.

c. plan transitions from one activity to another.

Example: Give both preschool and older children a five minute warning when an activity is ending.

Example: Use a song that cues the transition.

d. use foreshadowing techniques. Since young children do not adjust well to abrupt changes, they need to be prepared in advance. This is particularly true if the change is in the schedule to which they have become accustomed.

Example: If a field trip is being planned, prepare younger children by telling them what to expect on the bus trip. Act it out. Discuss the rules that will apply before the trip.

Example: Prepare older children by providing books and materials that will give them advance information about the place that they will visit. Tell them about the rules before the trip.

e. modify the environment to eliminate problems. Provide sufficient space and materials. Children may exhibit aggressive behavior in order to retrieve an object, privilege, or territory. It is difficult for children to determine whether or not another's act is accidental or intentional; therefore sufficient space must be provided in order to prevent accidental acts of aggression from occurring.

Example: Turn a toy shelf away from a group activity area, arrange furniture in such a way that running is not encouraged, keep drums and other loud instruments put away until music time. Providers should child proof the home by covering electrical outlets, putting all sharp instruments safely away, and viewing the area from a child's perspective.

5. Be sure that the child understands your expectations of him and be sure that you have reasonable expectations for an individual or group.

a. speak at the child's level. Do not speak either below or above the child's level. Do not patronize the child.

b. do not use commands when speaking to the child; however, always keep in mind that if you ask questions, you must live with the answer. If the child has no choice, state simply, "It's time for you to ...".

c. use limited choices rather than free choices. A child needs limitations. For example, instead of asking the child what he would like to play with, ask him if he would like to play with the blocks or the dolls.

B. Increasing Desirable Behaviors: Positive Reinforcement

1. What positive reinforcement is: Positive reinforcement consists of following a desired behavior immediately by something pleasant to encourage it to occur again.

a. positive reinforcers are something a person likes, for example food, a hug, or playing a game that the child enjoys.

b. one should use a variety of reinforcers.

2. What to reinforce: Reinforce the good behaviors that need to be increased.

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It may be necessary to have someone else observe the child in order to get a clear definition as to what the good behaviors are.

3. When to use reinforcement: You should begin by reinforcing the desired behavior each time it is exhibited until the behavior is well established. The reinforcer should immediately follow the desired behavior. Once the behavior is learned the reinforcer can be gradually reduced.

4. Ask the group for other strategies for increasing desirable behaviors that they have found to be successful.

C. Decreasing Inappropriate Behaviors

Discuss what these behaviors might be. Discuss the inappropriate behaviors exhibited by the age group represented by the participants present

1. Extinction: If the behavior is not serious but simply annoying, the best strategy is to ignore the behavior. (Examples of this behavior may be the use of unacceptable language or a habit of interrupting other people)

a. the behavior must be ignored every time it occurs. At first this technique may lead to an increase instead of a decrease in the undesired behavior.

b. in order for this strategy to succeed, everyone involved with the child must be consistent, the behavior must be ignored whenever it occurs.

2. Time out: This strategy is often overused. It should be used sparingly, and, for young children, for very short spans of time. If the undesired behavior occurs during an activity that the child enjoys, it may decrease the behavior to consistently remove him from the activity whenever the behavior occurs.

3. Substitution: Replace an inappropriate action, toy, etc. with a more appropriate one. For example, replace a dangerous toy with a safe one.

4. Logical consequences: Logical consequences are similar to allowing the child to suffer the natural consequences of his act but the adult intervenes because the natural consequences are too dangerous or no natural consequence is available.

a. examples of this would be a child playing in the street. The adult would intervene to prevent the natural consequence from occurring.

b. common mistakes that may occur when this strategy is employed:

1. *results not related to the problem*
2. *results not acceptable*
3. *not following through*

5. Negative reinforcement or punishment: This is something unpleasant that follows a behavior that causes the behavior to weaken or decrease.

a. use as a last resort

1. *doesn't teach the child what to do*
2. *can harm the adult/child relationship*
3. *it is not a long term solution to the problem*

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4. The adult is modeling a behavior that she doesn't want the child to imitate.

D. Group Discussion of Additional Strategies

Ask the group for other strategies that they have found helpful in decreasing undesirable behaviors. (Add the strategies to the above list).

IV. SOLVING PROBLEMS (List each step on the chalkboard/flipchart)

A. Steps to follow

1. Define the problem behavior: The problem must be clearly defined before it can be eliminated. The first step is to determine what the specific behavior is that is causing problems. A consultation of all the adults involved may be necessary in order to identify the problem.

2. Gather data about the problem. Document such information as:

a. how often the behavior occurs

b. at what time of day the behavior occurs

c. who is present when the behavior occurs

d. what happens before and after the behavior occurs

d. what you think may be triggering the problem.

3. Think of all possible solutions to the problem. Consult other teachers, other professionals who come in contact with the child, and the child's parents.

4. Considering all the possible strategies, determine which one seems most appropriate for this child in this particular situation.

5. Evaluate the results. Meet again with the other adults involved after several days to see if the chosen strategy is working. If not, choose an alternative approach to the problem.

B. Group Activity

1. Break the participants into pairs (preferably pairs that work with the same group of children). Provide each pair with paper and pencil. Tell the group that you want each pair to identify a specific behavior problem in their class, write it out, and develop a behavioral plan.

2. Bring the group back together to share the plans. Discuss the plans. Should the plan be successful with the targeted child? Does anyone have any suggestions as to how it could be adapted?

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V. SUMMARY

Summarize the main points of the workshop: (1) that children with special needs and children who are developing normally have many of the same behavior problems. Emphasize that the main differences may lie in the intensity of the behavior and the rate at which the child develops. (2) Stress the fact that adults should set limits and have behavioral expectations of all the children with whom they work; that if they do establish the fact that all the children are expected to adhere to the rules of the group, follow the limits that have been established, and meet certain expectations, that all the children will behave more appropriately and develop more positive self-esteem.

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BLURPLAND ACTIVITY

To the facilitator: You are going to have a "party", held in Blurpland. Blurpland has a special set of rules for parties; you will be the native Blurplander. When a group member breaks a rule, you'll respond as stated in the rules below. You'll run the party twice...the first time, YOU WON'T TELL THE GROUP THE RULES UNTIL AFTER THE PARTY. The adults may feel some of what children feel when they're growing up,

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and don't yet know the rules. They'll see for themselves how much easier it is the second time, when you've told them the rules ahead of time. For props, you'll need napkins, which you'll distribute to the group. You'll serve "donut holes" to eat.

RULES (Remember to keep them secret until after the first run-through).

1. First, at Blurpland parties people are supposed to talk and make a lot of noise. Even if they cannot think of anything to say, they should bang on the table or start whistling.

2. No fingers on food-they may use their palms, but touching food with fingers is thought to be bad. If the participants use their fingers, point at them and make a disapproving noise. Don't tell them what is wrong.

3. Napkins are kept on a shoulder, not in the lap.

4. In Blurpland people say "thank you" when they want something and "please" after they have gotten it and want to express gratitude. So if people say "please" when they are offered something (like food), the person who is offering it should wait to hear "thank you" before giving the food.

For the party, have participants sit down around a table or pull their chairs into a circle. After they are seated, give participants napkins, but don't say anything. Hand them their napkins by placing them on their shoulders.

Now go around with the donut holes and stop next to each person. Ask, "Do you want one of these?"

WHAT THE PARTICIPANTS MIGHT DO	WHAT YOU WILL DO
1. Say "Yes", or "Yes, please."	1. Wait to hear "thank you". If you don't hear "thank you", say "maybe another time" and move on.
2. Say, "No thank you."	2. Say, "Make up your mind!"
3. Say, "Thank you."	3. Give them one and wait for them to say "please." If they don't say "please" they've been rude. Take the donut hole back.

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While you go around the table, mutter to yourself about what a rude group of children you are trying to entertain.

After you have gone around the table once, pick two people who have been especially noisy and outgoing, and give them each some donut holes. Tell the group, "At least two persons know how to act. The rest of you are hopeless."

As the two people begin to eat, point at their fingers and make clucking noises in a disapproving way.

After they have finished, tell the group that the Blurpland party is over.

ASK: How do you feel about this party?

TELL: Now we're going to try the party again, but this time I will tell you the Blurpland rules, so you'll know what is going to happen:

1. First, at Blurpland parties people are supposed to talk and make a lot of noise. Even if you cannot think of anything to say, you should bang on the table or start whistling.

2. No fingers on food; palms are okay.

3. Napkins are kept on your shoulder.

4. "Thank you" means "please." After you get something, you must then say "please".

Repeat the activity. It will go better this time because the participants know the rules.

Discussion. Ask what things changed in the second party?

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LIST OF PREVENTION TECHNIQUES

1. Modeling the behaviors I want my child to imitate.
2. Letting your child learn from experience or from the natural consequences of his actions.
3. Planning ahead
 - a. plan activities to reduce boredom
 - b. restructure time
 - c. plan transitions
 - d. foreshadowing
 - e. modify the environment
4. Have clear expectations for your child.
 - a. speak at the child's level
 - b. questions vs. commands
 - c. limited choices vs. free choices
 - d. Grandma's rule

PLANNING AHEAD HANDOUT

1. Plan activities to reduce boredom.
2. Restructure time.
3. Plan your transitions between activities.
 - a. natural transitions
 - b. warnings before transitions
 - c. rituals
4. Foreshadowing (explaining new activities to your child)
5. Modifying the environment
 - a. limiting the environment
 - b. adding to the environment
 - c. changing the environment

REINFORCING "GOOD" BEHAVIOR WORKSHEET

1. Pick a behavior you would like your child to do more of and clearly define it.

2. Decide on an appropriate positive reinforcer for your child.

3. How will you reinforce the child when she is just learning the behavior?

4. How will you reinforce the child once the behavior is well learned?

"COMMON PROBLEMS USING REINFORCERS"

If you are trying to reinforce a behavior and the behavior is not increasing, something is wrong. There are 4 questions to ask yourself in trying to solve the problem.

1. Am I positively reinforcing the behavior IMMEDIATELY after the behavior takes place? Even a small delay will cause positive reinforcement to be less helpful.
2. Am I positively reinforcing the desired behavior every time it occurs?
3. Is the "reward" something that the child really wants?
4. Is the desired behavior specific enough that someone else could use it and reinforce your child?

STEPS IN PROBLEM SOLVING

1. Define the problem behavior
2. Gather data
 - a. How often does the behavior happen?
 - b. What time of day does the behavior happen?
 - c. Who is around when the behavior happens?
 - d. What happens before and after the behavior occurs?
 - e. What may be causing the problem?
3. Ask yourself some questions
 - a. What have I already tried?
 - b. What works with this child?
 - c. What can I do to prevent the problem behavior?
 - d. Is the behavior common for this age?
 - e. Do I need to re-evaluate my expectations?
4. Brainstorm
 - a. List all possible alternatives
 - b. Ask other teachers for ideas
 - c. Ask the child's parents for ideas
5. Choose an alternative to try
6. Evaluate the results
 - a. How did your alternative work?
 - b. Do you need to try another alternative?

ENCOURAGING WORDS

Too often, we make positive comments in a praising manner. Such comments express our values and opinions, rather than help children believe in themselves. To express the special meaning of encouragement eliminate value-loaded words (for example, good, great, excellent).

Phrases that demonstrate acceptance:

"I like the way you handled that."
"I like the way you tackle a problem."
"I'm glad you enjoy learning."
"I'm glad you're pleased with it."
"It looks as if you enjoyed that."
"How do you feel about it?"

Phrases that show confidence:

"Knowing you, I'm sure you'll do fine."
"You'll make it!"
"I have confidence in your judgment."
"That's a rough one, but I am sure you'll work it out."
"You'll figure it out."

Phrases that focus on contributions, assets and appreciation:

"Thanks, that helped a lot."
"It was thoughtful of you to _____."
"Thanks, I really appreciate _____, because it makes my job much easier."
"I need your help on _____."
"You have skill in _____. Would you do that for the family?"

Phrases that recognize effort and improvement:

"It looks as if you really worked hard on that."
"I see that you're moving along."
"I'm glad you tried that."
"Look at the progress you've made." (Be specific, tell how.)
"You're improving in _____." (Be specific.)
"You may not feel that you've reached your goal, but look how far you've come!"

Are most of your words and phrases encouraging? Get firm when needed - but remember - most of the day should be spent in supportive efforts toward the child.

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WORKSHOP V: ORGANIZATION FAMILY INVOLVEMENT

Objectives:

1. To understand how to make families feel comfortable when talking with or working with child care providers.
2. To understand how to involve families in the decision making processes if they wish to be involved.
3. To understand how to convince parents to be consistent with program strategies at home.
4. To establish understanding between family and child care providers so the child will experience consistency in the approach taken in his home and in the child care setting.
5. To enable the child's experience to be broadened in its conception to include the home environment.
6. To benefit the child care providers by enabling them to gain first hand knowledge of the child's home environment.
7. To understand how to provide educational materials to parents.

Materials:

1. Flipchart or chalkboard
2. Marker or chalk
3. Handouts

Preparation:

1. Set out the flip chart, marker, or chalk.
2. Duplicate enough copies of the handouts for each participant to have a set.

Background Information:

This workshop uses the term "family" to mean a variety of family configurations linked biologically or affectively. Although most professionals realize the importance of involving parents in the day care setting, it can be very difficult to get an active family involvement program started. Caregivers often become discouraged and adopt the attitude that families just don't care. This is not the case. Many families care deeply about the setting in which their child receives care and want to be as involved in it as possible; however, they may be working and/or are burdened with several small children. Furthermore, families may not know how to become involved in the program in which their child is receiving care.

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WORKSHOP V: OUTLINE FAMILY INVOLVEMENT

NOTES

I. GETTING ACQUAINTED/INTRODUCTION

A. Ice Breaker

This icebreaker requires team work and problem solving. Break the participants into groups of four. Give each group a sack including the following objects: one raw egg, some straw, a small plastic bag, a piece of thread (approximately a yard long), a 4"x6" piece of aluminum foil, and a paper towel. Tell the groups that the egg is their baby. They are to use the materials to protect the baby in such a way that when the egg is dropped from (what ever is a high point in your meeting place) that the 'baby' will not be hurt. They are to use only the materials that you have supplied to them to protect the baby. Give the groups ten minutes to meet to solve the problem. Then have each group drop its egg. Relate the activity to the focus of the evening, working with parents to provide the best possible program for their child..

B. Discuss What Families Are Like

Ask the group to brainstorm ideas. Write the ideas on the flipchart/chalkboard. Be sure they include family needs, resources, and functions. After the ideas are exhausted, have them compare the list to their own needs. Ask how the families of the children for whom they provide care differ from their own families in needs, functions, and resources.

C. Discuss Child Care Providers Involving Parents

What benefits can the care provider expect the child to receive from having his family involved in his program? What benefits can the care providers expect to reap from having the family involved in the child's program? Why would it be of benefit to the family to be involved in the child's program?

D. Summarize

Emphasize that in order to be successful at getting families involved in the child care setting, the child care provider has to be committed to the task even when it seems hopeless. State that she has to be convinced that the benefits of establishing a partnership with the child's home life far exceed the frustrations that may result when the first overtures are made.

II. STRATEGIES TO CONSIDER FOR DEVELOPING FAMILY INVOLVEMENT

A. Discuss

What are the care providers doing presently to enhance family involvement? List each approach that is being used. Discuss the success of each approach. Ask for suggestions from the participants on how some of the approaches might be modified to make them more successful.

B. Family Involvement Approaches for Center Care.

1. Family contacts

- a. informal contacts: Informal contacts may occur when the child is brought to the center and when she is picked up. A unique opportunity is presented at this time to become acquainted with the family and to

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discuss family concerns. Some programs have found that it is beneficial to plan for assistants to care for the children during this time to enable the care provider to chat informally with the family. A time to build rapport with the family may also occur if the care provider encounters the family in the community. This kind of an encounter should be used only to build rapport, not to discuss problems that may be occurring with the child.

b. formal contacts: Examples of formal contacts are conferences, newsletters, parent handbook, bulletin boards, home visits, and phone calls regarding the child.

2. Family Contacts in the Family Care Setting

a. informal contacts: If child care is provided in a home setting, the family may bring the child to the home and pick the child up. As in the center, this is a time when informal interactions can take place between the family and the child care provider. As in the center, if the home care provider has the opportunity to spend time with the family during the arrival and departure time, it will contribute to the family's feeling of involvement in the child's care.

b. formal contacts: These contacts may include times when the family is asked to come to the care setting to a planned event, to help plan the child's care, or to help with a field trip or special celebration. During the conferences in which the child's care is discussed, the family should be asked for information about the child: information about his likes and dislikes, fears, self-help habits, and any health problems such as allergic reactions to food or other substances.

3. Involving Families in Education

a. all efforts to provide educational material to the family should follow two basic guidelines: It should be (1) convenient and (2) relative to their needs and interests.

b. varied formats might include: newsletters, speakers, bulletin board displays, observation guides, and observation in the day care setting.

c. topics might include such issues as: child development information, nutrition, television philosophy, behavior management, and self-esteem.

d. families benefit by observing their child in the care setting. They gain invaluable information about their child by observing their child's abilities, both social and developmental, in comparison to the normally developing children in the child care setting. The differences in abilities may be a shock to the families. The child care provider should be prepared to discuss these differences and also to stress the similarities between the children.

4. Family Involvement in the Overall Program

a. families can be involved in the general program in both a day care center and in a family day care by helping with planning if they wish to be involved on this level. They can help develop the philosophy, goals, and objectives. They can serve on a decision making board, can

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help with fund raising decisions.

b. families can help with the overall program by helping implement activities. They can make materials, help plan and implement field trips, and volunteer in the care setting.

c. families can be invaluable in helping evaluate the program by participating in opinion seeking surveys or interviews. They may simply be asked, "How do you think it's going?"

5. Family Involvement in the Child's Program

a. families can provide information that will enable the child care provider to plan more appropriately to meet their child's needs. Ask participants what kind of information families can provide. They can provide information to both the family day care and the center care provider about their child's likes and dislikes, fears, and specific health needs. They can tell you what will motivate their child. They can also give you information about their family, information about what the family needs for the child to learn, information about the child's interactions with siblings, and information about the child's interactions with adults.

b. if families are involved in decisions regarding the approaches and strategies used in the classroom with their child, they are more likely to support the program by following through at home. For example, if a specific behavior is discouraged in the setting, families will be consistent in using the approach at home if they have been involved in developing the approach that is used to discourage the behavior.

C. Support Groups

1. In order to integrate children with special needs into the child care setting, it is important to also integrate families of children who are normally developing with families of children with special needs. Parent support groups may fill this need with families meeting regularly on an informal basis, discussing those issues that are of importance to them.

2. When plans are initiated to integrate a child with special needs into the program, it may facilitate matters to discuss the issue with other parents informally. An informational flyer may be disseminated about the intentions of the program to integrate. The informational sheet should include the fact that experience indicates that integration benefits everyone involved, children with special needs, their parents, normally developing children, and their parents.

D. Brainstorm Strategies

These activities might be used to find out how parents want to be involved in the overall program. Suggestions could include a questionnaire, an interview, or an informal survey.

E. Other Families

State that one effective method that has been used to get families involved is for other parents to involve them. For example, a telephone tree might be established to notify families of upcoming events or meetings of the support group. Parent to parent contact

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has found to be one of the most effective means of getting families involved in the child's care setting.

III. COMMUNICATION SKILLS

A. Discuss the Importance of Communication Skills

State that parents are easily intimidated or frustrated by those in charge of their children, so it's especially important for child care providers to use such skills as:

1. Attending (paying attention to what the other person is saying)
2. Asking questions to clarify what the speaker has said
3. Using body language that indicates interest and respect for the speaker
4. Speaking in easily understood terms--no jargon.

IV. BARRIERS TO PARENT INVOLVEMENT

A. Encourage Discussion

The group should discuss problems they have encountered in their efforts to involve parents in the overall program or in their child's program.

B. Barriers

1. Families don't have time. This is a serious concern. In many families both parents are working and are very limited in the time they have to devote to other activities. This constraint makes it even more important to be sure that if you have parent meetings or ask parents to volunteer their time, that the time is wisely used and is beneficial to the parent, the program, and to the child. Parents often also have more than one child and thus can't spend all their time on one child's program.

2. Families don't seem to want to be involved. If this appears to be the case, ask yourself why? It may be because they don't feel comfortable in the classroom environment, they may have a low self-esteem, they may be experiencing too much stress and/or may have personal problems. Some child care providers become so frustrated that they begin to feel that the parents don't care what happens to the child. This is not true. Parents care very much about their child; however, they may feel inadequate in an unfamiliar setting.

3. Families seem to lack the skill/knowledge to be involved in the child care program. All adults have some skills that can be encouraged. It may take some probing to discover the skill that a particular family has to offer. If a family would feel comfortable volunteering in the setting, center or family day care, young children may just need someone to listen or to help them (another pair of hands) and older children may need someone to talk to or to listen to them read or help with a project.

4. The family is intimidated. This barrier may exist because of a past experience. Informal contacts can help eliminate this attitude over a period of time.

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V. SUMMARY

There will be a more meaningful experience for everyone involved, if the families become involved in the setting in which their child receives care. The care given the child will be more appropriate for the child, the family, and ultimately for the program itself. For this reason, it is important to encourage the families to become involved at whichever level they want to be involved.

This type of involvement may be especially important for the parents of a child with special needs. As they see their child in comparison to normally developing children, they may be shocked, and need support from others. They will need to be reassured of the similarities between their child and the other children. They also need to have contact not only with parents of children with special needs, but also with parents of normally developing children.

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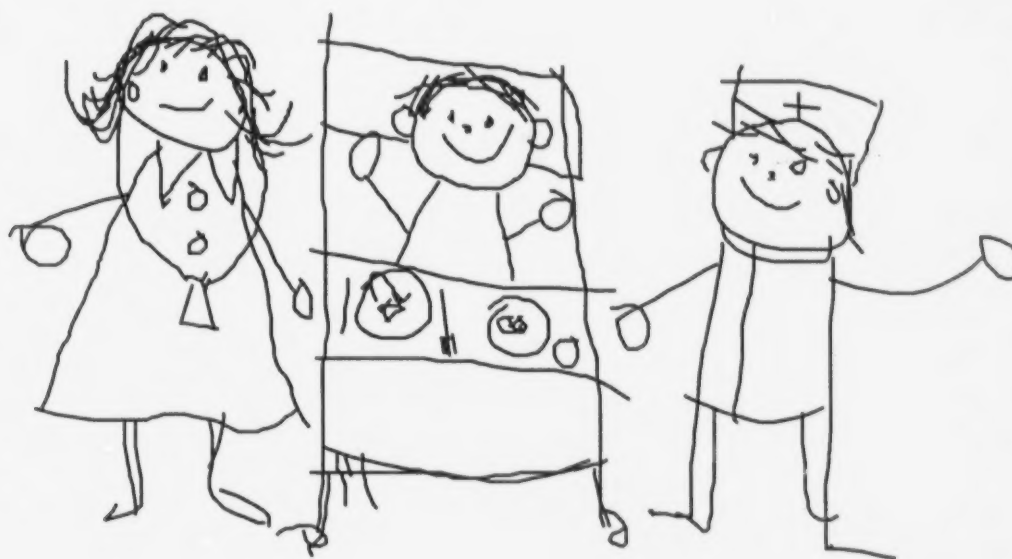
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WHAT IS HIGH RISK ?

The term "high risk" or "at risk" refers to children with a greater than normal chance of showing developmental delays at some point in early or later childhood. For school age children, this may be exhibited in school failure or possible involvement with the juvenile justice system. The State of Illinois describes three types of risk:

established risk- diagnosed medical disorders of a known etiology bearing relatively well known expectancies for developmental outcomes within varying ranges of developmental disabilities (e.g., Down Syndrome, Fetal Alcohol Syndrome, orthopedic, oral, maxillofacial, chromosomal disorders).

biological risk- a history of prenatal, perinatal, neonatal, or early developmental events suggestive of biological insults to the developing central nervous system and which either singly or collectively increase the probability of developing a disability/delay based on a medical history. Examples of children with this type of risk include children with low birth weight, were born small for gestational age, had anoxia (lack of oxygen), sepsis, etc.

environmental risk- families and children who are biologically sound, but whose life experiences, including maternal and family care, health care, nutrition, opportunities for expression of adaptive behaviors and patterns of physical and social stimulation are sufficiently limiting to the extent that they impart high probability for delayed development. Examples of children who might have environmental risk factors are children of teenage mothers, children whose families are involved with Protective Services of the Department of Children and Family Services, homeless children, etc.

The degree of risk is just as high with environmental risk as it is with established or bio-

logical risk. Socio-economic status is the best factor used to predict later I.Q. It is also true that children born in low SES families are more likely to have other established or biological risk factors.

SPECIAL CATEGORIES OF HIGH RISK CHILDREN

Cocaine Babies

Cocaine can affect a pregnant woman and her baby in numerous ways. Cocaine causes smooth muscles to contract. The smooth muscles are the heart and the uterus. In early pregnancy, cocaine can cause miscarriage. In mid to late pregnancy, cocaine can cause premature labor. It can also cause the placenta to separate from the uterus before or during labor. This condition, called a placental abruption often leads to extreme bleeding and can be fatal for both mother and baby.

In addition to the effects of prematurity, many of these infants do not grow well in utero and have low birth weights. Babies born less than five pounds eight ounces at birth are forty times more likely to die during the first month of life than normal babies.

Some babies which have been exposed to cocaine in utero will have a stroke, which can cause irreversible brain damage. Occasionally they have other internal organ malformations, especially of the genito-urinary tract. They also have an increased risk of dying from Sudden Infant Death Syndrome (SIDS).

Once born, these babies are very jittery and irritable. They startle and cry and are unable to calm themselves. They have increased tone and reflexes and are often described as stiff. Often these babies are very difficult to console while they are going through a period of withdrawal in the first three months of life. Because these

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babies are often hyperirritable, they are often not able to interact with their mother or other care providers. These babies are easily overloaded, so they frequently shut down into a deep sleep and are seen as nonresponsive or withdrawn. In their early months these babies are either crying and agitated or in a deep sleep.

Their behaviors cause these babies to be difficult to interact with and comfort. Their inability to interact combined with a mother who continues to be drug dependent sets up a cycle of poor bonding between mother and child. Because they are so difficult to nurture, and give so little positive feedback, their mothers and other caregivers are frustrated and have little patience with them. These babies are at an increased risk for child abuse or neglect.

Cocaine babies are often calmed by being tightly swaddled in a receiving blanket. They also are better able to calm themselves if allowed to suck on a pacifier.

Research is not complete as to what will be for these children after infancy. Because of bonding problems and frequent poor health, they are considered "high risk for developmental and learning disabilities" according to Dr. Ira Chasnoff, a developmental pediatrician at Northwestern University who has done extensive research on babies whose mothers used cocaine during pregnancy. The long range effects are not yet available, but are currently under investigation. A major challenge is to support the mother and still protect the infant by promoting parent-infant interaction (see the section on Families of Children with Special Needs).

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) was first identified in 1972. It is a combination of physical and mental birth defects that directly relate to alcohol consumption during pregnancy. The major char-

acteristics of this syndrome are growth impairments, delays of fine and gross motor development, and congenital malformations of the face. FAS is often associated with mental retardation (see module on Cognitive Impairments).

Babies born with FAS are abnormally small at birth, and continue to grow slowly. Their characteristic facial appearance includes widely spaced eyes, often with droopy eyelids, a short upturned nose, no groove in the upper lip, and small flat cheeks. Sometimes there are associated cardiac defects or a cleft palate. Most children with FAS have small brains and some degree of mental retardation with IQ's less than seventy. Hyperactivity and short attention spans are common behavior problems for these children (see module on Social/Emotional/Behavioral Problems).

The physical, cognitive, and behavior problems that most children with FAS have are frequently compounded by their home environments which may be dysfunctional. Often their parents have alcohol or drug problems which may inhibit them from providing for basic needs. Generally the child's developmental delays escalate because of the mother's addiction.

The incidence of FAS varies according to source, ranging from one to six per thousand live births. There are even more children born with fetal alcohol effect (FAE) which is a milder form of the syndrome, frequently without all or some of the identifiable facial characteristics.

Not all children with a particular syndrome are identical. Each must be treated as an individual with respect for their own unique strengths and weaknesses.

Acquired Immune Deficiency Syndrome (AIDS)

AIDS is caused by a virus that destroys a person's defenses against infections. The AIDS virus,

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known as human immunodeficiency virus (HIV), weakens a person's immune system so that he cannot fight off even the mildest illness or infection. The virus can also attack the nervous system causing brain damage. Children can catch the AIDS virus from a variety of sources. The most common method of virus transmission for children is through the placenta during birth. Children born to HIV positive mothers may also test HIV positive. The other common source is through a blood transfusion, although this is now rare or nonexistent because all blood is now tested for the AIDS virus. Infants who are born with AIDS usually do not live beyond the age of two years. They do not die from the AIDS virus, but from another illness that they were unable to fight. For this reason, placement of a child with AIDS in a group child care situation should be carefully considered. Because most group child-care settings are "hotbeds" of infection, this situation places the child at an extremely high risk for catching an illness that could eventually be terminal. It is strongly recommended that very young children with AIDS be cared for in as healthy an environment as possible. The most likely place may be a day care home with few other children or in the child's own home with a private caregiver. This is especially true for children who lack control over bodily functions, have open wounds or cuts, or display behavior such as biting. Regardless of the child care setting, it is of the utmost importance that strict hygiene practices be observed. Day care providers should wear gloves whenever dealing with body fluids such as urine, feces, vomitus, or blood. Double bagging procedures should be used for discarding diapers and other materials used to clean up body fluids.

Caregivers should know that there have been no reported cases of a caregiver or parent getting the AIDS virus from a child. No cases have been reported of one child getting AIDS from another child. There would be no reason why a child with

AIDS should not participate in after school or summer recreation programs as long as the child's physician has been consulted and agrees to the placement. Parents should be notified whenever the children have been exposed to any highly contagious disease. Strict confidentiality regarding a child's medical history should be observed.

CHARACTERISTICS OF THE HIGH RISK CHILD

There is wide variability in the characteristics of high risk children. Much depends on the type of risk factors that are involved. Specific characteristics that can be observed in many children are in the areas of temperament, attention span, activity level, and health.

infants- high risk infants may be difficult to comfort, may be irritable, hypersensitive, lack responsiveness to caregivers, have irregular sleep habits, and/or have feeding difficulties. They are also likely to have more medical problems such as upper respiratory illnesses, ear infections, and asthma.

toddlers and older children- high risk toddlers and older children are also likely to have the same types of medical problems as the younger children. In addition, they may exhibit hypoactivity or hyperactivity, behavior problems, short attention spans, and delayed development. Learning disabilities are common. Sleeping and eating problems may also persist.

FOLLOW UP WITH HIGH RISK CHILDREN

Regular follow up is important with high risk children. Two types of follow up are necessary—medical and developmental. It is important that high risk children receive regular pedi-

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atric exams. The frequency that is required by day care licensing standards is probably not enough for the high risk child.

Developmental follow up should be ongoing. The purpose of developmental follow up is to catch mild developmental problems before they become bigger ones. Developmental screening tests such as the Denver Developmental Screening Test can be done as part of routine pediatric examinations or they can be done by other health providers, schools, or agencies. Day care providers are good observers of children because they may see the child daily on an ongoing basis. They may also be able to compare children of the same age. The information included in the "Identification Workshop" will be helpful for the purposes of following up high risk children.

PROFESSIONALS WHO MAY BE INVOLVED

medical professionals- pediatrician or other medical doctors such as neonatologist or otolaryngologist, public health nurse, follow up clinic staff.

educational professionals- early intervention program staff, Headstart program staff, public school high risk program staff, therapists (speech/language, physical therapy, occupational therapy).

SPECIAL PROGRAMS FOR HIGH RISK CHILDREN

Follow Up Programs

Many communities or counties have programs that follow high risk children that are referred directly from hospitals. The State of Illinois has a program called the Adverse Pregnancy Outcome Recording System (APORS). In the APORS system, children are visited approxi-

mately every four to six months in their homes. This can be done by public health nurses or other early intervention programs. On the home visit, children receive a brief physical exam, as well as a developmental milestone screening. In addition, information about family function and family needs is obtained through discussion with the primary caretaker(s). If the child is showing developmental delays or health problems, he is referred to other programs for follow up as needed. Not all high risk children are in this system. Children who do not meet the criteria for APORS may be followed in the same or other programs. Some agencies have special "high risk" intervention programs that follow children that need to be followed more closely than every three to four months but do not yet show developmental delays. These programs are usually aimed at enhancing family strengths and helping the family to provide a stimulating environment for the child.

School Based Programs

Many public schools now have programs for high risk preschoolers. These programs usually have a center based component and a parent involvement component. In the center based component, the children are provided with a half day preschool program that usually has a strong emphasis on speech and language. These programs are very similar to the usual developmental preschool classroom. The only difference is that a speech and language pathologist is part of the program staff. Other types of follow up and developmental assessment programs are readily available as needed. The parent components vary greatly. Some programs include regular home visits as part of the curriculum. Most programs encourage parent volunteers. Some programs offer GED classes on-site. The possibilities are endless.

Some children who attend public school high risk programs are also in day care. It is important that

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the classroom teacher, the caregivers, and the parents work together to make all these settings helpful to the child. One thing to be careful of when working with children who are "dually enrolled" is that the child is able to handle the different expectations of the two different settings. Be aware of signs of stress that indicate that a dual placement may be too much for the child.

Headstart

Headstart has been with us for over twenty years now. It was originally started as part of the "War on Poverty". Any child of a certain age (usually four) whose family meets certain financial criteria is eligible for the Headstart program. The Headstart program is composed of several components: 1) educational component, 2) social service component, 3) health component, and 4) parent involvement component. Headstart serves children in both home and center-based programs. 10% of the total enrollment must be handicapped. Many children who are enrolled in Headstart programs are also involved with other programs for high risk children. It is possible for a child to attend three programs in one day! He may attend a public school program in the morning, a Headstart program in the early afternoon, and then go to day care from 2:30 to 5:00. This requires a great deal of coordination on the part of the service providers and the child. Coordination of services is extremely important in situations such as this.

SUGGESTIONS FOR INTEGRATING THE HIGH RISK CHILD

1. Identify all developmental delays as soon as possible so that intervention can begin.
2. Be aware of the health and medical needs of the high risk child. Make sure recommendations from medical personnel are taken into considera-

tion in planning and carrying out activities and daily routines. See the "Health Needs" module for more information on this topic.

3. Make sure to cooperate and communicate with other programs serving the high risk child and family. See the "Procedures" section for information on this topic.

4. Have reasonable and consistent expectations for the child with a short attention span. See the module on "Social/Emotional/Behavioral Needs" for more on this topic.

5. Help the child to develop GOOD SELF ESTEEM!!!!

6. Encourage and support the relationship between the child and his family. See the section on "Families of Children with Special Needs" for more information on this.

7. Some high risk children may be in foster care. These children need to develop trust first and foremost. Caring and consistent caregiving is the best way to do this.

8. Help children learn to anticipate events, understand the behavioral expectations of different settings, develop perseverance, and learn to understand what other people's behavior means.

9. Help the child to increase his communication skills. See the module on "Speech and Language Needs" for more information.

10. Follow good hygiene practices. See the section on "Health Needs" for more information on this.

11. Inform parents of support groups for parents of children with special needs or groups that address other needs of individual family members. Some examples are Al-Anon, Parents Without

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Partners, adult education programs, parent education classes, sibling support groups, etc.

12. Some methods for calming an irritable infant are swaddling, rocking, letting the child suck on a pacifier, using an infant swing, going for a stroller ride, singing to him, playing soothing music, having the infant look in the mirror, and many more.

SUGGESTIONS FOR TRAINING

General Topics

- working with families
- identifying children with possible special needs
- behavior management
- language enrichment (any topic relating to this)
- health and hygiene practices

Topics of Interest for Caregivers of High Risk Children

- information sessions on specific high risk categories (e.g., FAS)
- working with children served by multiple programs
- typical and atypical infant development
- working with children in foster care
- attention deficit-hyperactivity disorder
- children of addicted parents (e.g., children of alcoholics)
- children with learning disabilities

Suggestions for Speakers or Consultants

- public health nurse
- early intervention program staff
- family therapist or counselor
- substance abuse worker
- neonatal intensive care nurse
- special educator (egs. learning disabilities teacher)
- physician

RESOURCES

Your local public health department and other developmental clinics or centers are good sources of information on how to follow up high risk children.

National AIDS Hotline— 1-800-342-AIDS

For information on cocaine babies— 1-800-327-BABE

Illinois AIDS Hotline— 1-800-AID-AIDS

Illinois Birth to Three Clearinghouse
830 S. Spring Street
Springfield, IL 62704
217/785-1364 FAX 217/524-5339

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HOW HEARING LOSS AFFECTS THE CHILD AND THOSE AROUND HIM

The importance of good hearing cannot be stressed enough. The ability to hear affects communication skills, social-emotional development, and cognitive development. Even a mild hearing loss can cause serious difficulty in speaking and listening. This same mild hearing loss can inhibit the child's interactions with other children and adults, as well as cause damage to the parent-child relationship because of the child's inability to attend or respond consistently or appropriately to vocal communication. The effects of hearing impairment multiply with the increasing degree of hearing loss. Many caregivers are unaware of how hearing impairment impacts on the child's inability to communicate. They have frequently been known to comment that "I know Joshua can hear. He turns when I clap my hands behind his head." They often do not understand that although a child hears sound, he may not hear it well enough to learn to imitate or understand speech. Hearing impairment can be misdiagnosed as a behavior problem, emotional problem, mental retardation, or speech/language problem. Even the most severe hearing loss is not always easily detected. It is important to help the caregiver understand the nature of hearing loss, because this will affect the way the caregiver interacts with the child. A very effective training activity that will help a caregiver to understand how even a mild hearing loss can affect the listener is "An Unfair Hearing Test", which can be obtained from the Council for Exceptional Children (see Resources). In this activity, participants listen to a pre-recorded "spelling test". To the listener, the words sound as they would to a person with a mild hearing loss. Participants are to write down what they "think" they hear. Listeners experience great frustration when they hear a spoken word, but cannot tell what it is. This activity can have a tremendous impact on the way a caregiver interacts with a hearing-impaired child.

PREVALENCE OF HEARING LOSS

Hearing impairment is one of the most common handicapping conditions in children. It is estimated that 2-5% of children may have hearing impairments that require medical or special educational attention. Hearing impairments can range in severity from a mild conductive hearing loss caused by middle ear fluid (common in children with frequent ear infections, colds, or allergies) to severe/profound hearing loss or deafness.

TYPES AND CAUSES OF HEARING LOSS

Audiologists (hearing specialists) describe sound in terms of frequency, or pitch, and decibels (dB), or loudness. Caregivers need to know a few basic facts about frequency and decibels in order to understand a particular child's hearing loss. Speech sounds have different frequencies. Hearing Handout 1 shows the frequencies of different speech sounds. By looking at this handout, a caregiver could see that a child with a high frequency hearing loss may not be able to hear the sounds made by the letters "f", "s", and "th". If a child cannot hear a sound, he will probably not be able to say it. Hearing Handout 2 "Sound Levels in Decibels", and Hearing Handout 3 "Degrees of Hearing Loss" can be used to help the caregiver to understand how loud a sound must be for a specific child to hear it, as well as the severity of the hearing loss. For example, a child with a 50 dB hearing loss will probably hear a great deal (although he will probably not understand every word spoken), whereas a child with an 80 dB loss will hear very loud sounds but little else. Speech will be very difficult for this child who will probably not be able to use sound as his primary means of communication.

Conductive Hearing Loss

Conductive hearing loss is the most common type of hearing loss. With this type of loss, sound

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cannot adequately get through the outer or middle ear to the inner ear. This type of loss usually does not cause more than a 60-70 dBs decrease in hearing ability which is in the mild to moderate range of hearing loss. With this type of hearing loss sound is muffled or in some way distorted (similar to the sounds that one might hear "under water" or what you hear when your hands are over your ears.) One of the most difficult parts of this kind of hearing impairment is that the degree of hearing loss may fluctuate from day to day. In other words, the child may be able to hear adequately one day but not the next day.

Conductive hearing losses are usually caused by fluid in the middle ear. This is usually caused by ear infections (see Hearing Handout 4 "Understanding Middle Ear Infections") or something in the ear canal (egs. wax, a bean, a piece of crayon). Conductive hearing loss may also be caused by a deformity in the ear or an injury to the ear (egs. poking a pencil through the eardrum).

Conductive hearing losses can usually be treated by a physician through the use of antibiotics, decongestants, or surgery.

Sensori-Neural Hearing Loss

Sensori-neural hearing loss usually involves damage to the structure of the inner ear or the auditory nerve. It is less common than conductive hearing loss. An inability to hear high frequency sounds is very often present. Sensori-neural hearing losses can involve all ranges of loss in one or both ears.

Possible causes of sensori-neural hearing loss include disease during pregnancy, a high fever for more than a day or two, head injury, heredity, or viral infections. Sensori-neural hearing losses cannot usually be treated medically. They are permanent. Most children with sensori-neural hearing loss will probably need to use a hearing aid in one or both ears depending on the type of

loss.

Combination Hearing Loss

A child can also have both a sensori-neural and a conductive hearing loss. For example, a child with an inherited moderate to severe sensori-neural hearing loss may also be prone to ear infections which can lead to the build up of fluid in the middle ear causing a conductive hearing loss in addition to the sensori-neural loss.

HOW TO RECOGNIZE POSSIBLE HEARING PROBLEMS

It is important for caregivers to watch for possible hearing loss in children. The earlier a problem is detected the earlier intervention, be it medical or educational, can begin. At the end of this module are two handouts which caregivers can use to detect possible hearing impairments ("Does Your Baby Hear?" and "Hearing Checklist"). If one or more of the listed symptoms are present, the child's hearing should be screened.

A hearing screening can usually be obtained from any of the referral sources listed in the next section. Many local health departments will conduct routine hearing screenings for all children in a day care center. Children who fail hearing screenings, re-screenings, or have speech/language problems should be further evaluated by a specialist such as an audiologist or an ear, nose, and throat doctor (otolaryngologist).

WHERE TO REFER CHILDREN WITH POSSIBLE HEARING PROBLEMS

Sources for hearing referrals will differ depending on where you live. Some possible sources include:

1. Your local public health agency

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2. The child's pediatrician
3. An otolaryngologist or ear, nose and throat doctor (E.N.T.)
4. An audiologist
5. A university affiliated hearing and speech clinic
6. Your local school district

Caregivers are very reluctant to do formal referrals. They are fairly sure they know when there is a legitimate concern but they feel that somehow they are not qualified to express this concern to parents. Caregivers should be assured that they are very good referral sources. Referrals cannot be made without a parent's permission, and so it is of the utmost importance that caregivers be able to express their concerns with parents. Please see the Identification Workshop for more information on expressing concerns to parents. It can be very reassuring if a caregiver can talk to a professional or consultant about her concerns before expressing them to parents. If, after initial referral, the concern is considered to be valid, the child should receive a full audiological (hearing) evaluation. An audiological evaluation will give information on what the child can or cannot hear and what might be causing the problem. See handout #7 for more information on audiological testing. It is not necessary to explain testing techniques to the caregiver, but the day care consultant should help the caregiver to understand the results if a problem is identified. See the handout entitled "How to Read an Audiogram", for information on interpreting the results of a hearing evaluation. If you are still not sure about how to do this, most audiologists are very happy to discuss their findings and recommendations with you and/or the caregiver, provided they have the necessary releases of information.

PROFESSIONALS INVOLVED WITH HEARING IMPAIRED CHILDREN

Professionals involved with hearing impaired children may include any or all of the following:

audiologist-conducts screening and diagnosis of hearing problems, recommends hearing aids, and may provide some intervention to people with hearing impairments.

speech and language pathologist- conducts screening, diagnosis and treatment of children and adults with communication disorders (may also be called a speech therapist).

occupational therapist- evaluates and treats people who have difficulty performing self-help, play, or school related activities with the goal of developing independence.

teacher of the hearing impaired- has advanced training in teaching hearing impaired persons. They evaluate and work with people in clinics, special schools, special classrooms, or home settings.

otolaryngologist- a medical doctor who conducts screening, diagnosis, and treatment of ear, nose, and throat disorders. They can also perform ear, nose, and throat surgery. They may also be known as "ENT"'s (ear, nose, and throat).

HEARING AID INFORMATION

One of the first things that a care giver should understand is that hearing aids do not correct hearing the way that eyeglasses correct vision. Hearing aids, so far, can only make sounds louder. This means that, while speech sounds are amplified, so are environmental noises and sound distortions. (See Hearing Handout 8 "General Points About Amplification" for more information.)

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The most common type of hearing aid used with children is the BTE or "Behind the Ear". This type and others are shown in Hearing Handouts 9 and 10. The first thing a care giver should know about a child's hearing aid is how to put it in the child's ear! The parent will probably be the one to instruct the care giver in putting in the hearing aid if the child cannot do it himself. Opportunities for practice are usually quite plentiful when the child is below age three as it is very common for the young hearing aid user to remove the aid(s) several times a day or even several times an hour. Children over age three (developmentally) are usually able to put a hearing aid in on their own.

At first, the most important goal is consistent hearing aid usage. This can mean a pretty big commitment if the child is doing his best to keep from achieving the goal! This is probably the most difficult part of having a child with a hearing impairment and it is very frustrating to an already overworked caregiver. One thing that contributes to the problem is when parents do not follow through with consistent hearing aid use at home. Inconsistent hearing aid usage at home can lead to tremendous problems for day care providers. The only way to solve this problem is to work as a team with the family. If families, special service providers, and caregivers work together to achieve full time hearing aid usage, there will be fewer hassles in the group care setting. (See Hearing Handouts 11, 12, and 13 for more information on this topic.)

Parents should be encouraged to do daily hearing aid checks before the child comes to day care. Unfortunately this is not always done, so caregivers need to know how to tell if the hearing aid is working. There are a few ways to do this. One way is to turn the aid on and hold it to your own ear and listen. Another rather primitive way is to bring your cupped palm over the hearing aid. If it whistles it is working somewhat at least. If the

aid is whistling at other times, it may be turned up to high or the child may be leaning against something that is touching the aid. Keep in mind that these are very gross hearing aid checks. If the day care provider wants to do a more precise one, a battery tester is needed. These are inexpensive tools, and may be provided by parents. Decisions about this will need to be made on an individual basis.

Hearing aids can cause safety hazards in the day care setting. A child can easily remove his hearing aid, open the battery compartment and swallow the tiny battery. Most children have small bands around their hearing aids to keep the battery compartment closed, but this is not always effective. Caregivers should keep a watchful eye on the child with a hearing aid. The hearing aid can also be lost or damaged. The best protection against this is to train the child to wear the aid(s) for all his waking hours and not to take it out himself until he is old enough to avoid danger. This helps the child to feel as if the aid(s) is a natural part of his body.

Most children with hearing aids refuse to wear them when they have an ear infection. This is the only time, other than sleeping, that the child does not need to be required to keep his hearing aid in as it can be very uncomfortable for the child with an earache.

SIGN LANGUAGE

Sign language is not used with every hearing impaired child, but is commonly used when there is a severe to profound loss. The decision to use or not to use sign is made by the parent(s), and caregivers should implement their decision whenever possible. Sign language is usually part of the "Total Communication Approach". The total communication approach involves the use of a variety of forms of expressive language to com-

Section V - Special Needs Modules

municate. These forms usually include sign language, gestures, facial expression, body language, picture symbols, and print. Whatever approach is used, this should be thoroughly explained to all caregivers who are in contact with the child.

Caregivers may get very excited about learning sign and using it with all the children, or they may panic and never use it. This only serves to further isolate the hearing impaired child. Obviously, most caregivers do not know sign language, but caregivers of hearing impaired children who use sign should make an effort to learn as much sign language as is possible. A caregiver could learn sign from a deaf adult, from a college or adult education class, or from a sign language interpreter. Consistent signing should be modeled by the consultant if possible. The consultant should also encourage the other children to learn and use sign. The hearing impaired child can even help the group to learn sign. This has been observed with children as young as one year. Make sure the caregiver is reinforced for her use of sign. Make signing a fun activity. Some caregivers may continue to learn and use sign language even after the hearing impaired child leaves her care.

SUGGESTIONS FOR INTEGRATING CHILDREN WITH HEARING IMPAIRMENTS

1. Determine the child's existing hearing, aided and unaided, learn causes if known, frequencies child hears best/least, type of hearing loss, if child is involved with any other programs (early intervention, hearing education program, speech therapy, etc.).

2. Ask parents if they have decided on an educational approach (oral, total communication, etc.) and find out what this means for you.

3. Learn all you can about the child's hearing aid(s) (if applicable).

- types of aids
- how they work
- how to test batteries
- how to put in
- what to do if child takes them out
- hearing aid usage program
- who to talk to about the aids (usually the child's audiologist)

See section on hearing aids for more information.

4. Talk to the child as much as possible about what he is doing, what you are doing, labeling objects, etc.

- try to talk close to child's hearing aid whenever possible
- take advantage of one on one times such as diaper changing times for very young children

5. Try to respond to any and all vocalizations or attempts at communication that the child makes. You can repeat the child's sounds back to him, respond according to situations etc.

6. Augment the auditory sense with other sensory modalities. Make the environment very visually exciting. Label objects with words and picture symbols. Provide lots of sensory experiences such as:

- crawling over different textures of flooring
- looking at and handling touchy, feely, or scratch and sniff books
- having lots of water, sand, corn meal, beans play available on a daily basis
- outdoor play on grass and on playground equipment
- art activities that involve interesting textures

7. Encourage a wide variety of fine motor activities to help the child develop finger dexterity for signing. Some suggestions include:

- self feeding and the picking up of small bits of food

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- block play with a variety of block sizes and shapes
- pegboard activity
- fit a shape activity
- finger plays and songs
- bead stringing and other related activities such as placing rings on a post
- begin crayon and scissor activities early
- encourage artistic endeavors such as painting, drawing, pasting
- practice cutting
- use activity boxes and gadget boards
- a "lite brite" toy

8. Use gestures, sign language, facial expressions, tone of voice, and body postures to communicate with the child. Learn as much sign language as possible if the child will be using it. Some classes are offered free or very inexpensively.

9. Make your environment as quiet as possible in order for amplification to be effective.

- make sure the child is in a self-contained classroom (3 classrooms in one space is not good)
- avoid loud heating or air conditioning units and fans
- use sound absorbant materials like rugs and curtains (you can even carpet walls or the backs of shelving units)

10. Teach by demonstration as well as by telling.

11. Allow the child to sit near the teacher (and in clear view for lip reading) during group times.

12. Help the parent and child develop a positive bond. Be encouraging. Help the parent to understand what is "normal behavior" and what may be attributed to the hearing impairment.

13. Encourage symbolic activities such as dramatic or pretend play.

14. Use the child's name (and name sign) consistently in order to help the child associate her name with herself and learn to respond to it.

15. Make the child's environment as safe as possible as the child may not respond to warnings of danger.

16. Help the child to participate with other children at a level appropriate to her age.

17. If the hearing impaired child uses sign, teach sign language to all the children. Encourage them to use it with each other. Children as young as age two can teach sign to other children (and adults!).

18. Explain to others what the hearing impaired child wants.

19. Suggest games the children can play together (drop the hanky, chase, ball, swinging together on a glider, London bridge).

20. Emphasize activities that require fine visual discrimination (matching games like lotto, puzzles, bead stringing, nuts and bolts).

21. Use flannel board stories, allow the child to preview stories to be read to the group.

22. Play a feely box game where the child has to feel a toy, the sign, point to a picture, or choose a matching object.

23. Watch closely for visual problems as they are often related. See section on visual impairments.

24. Give the child extra time to respond as it takes the hearing impaired child longer to process oral communication.

25. Encourage the use of rhythm instruments and other noisy toys.

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26. Use behavior modification techniques with the hearing impaired child with all too common behavior problems.

27. Be on the look out for signs of childhood stress (see social/emotional module).

28. Let the profoundly hearing impaired infant lean against your body in order to feel vibrations made by your voice. Let the child feel your throat as you make sounds. Encourage the child to try it as well.

29. Be alert to the fact that a child with a conductive hearing loss will probably have a hearing ability that fluctuates. Slow your rate of speech somewhat and use short phrases with definite inflection and tone variations.

30. Do not shout when talking to a hearing impaired child.

SUGGESTIONS FOR TRAINING

General Topics

- identification
- middle ear infections
- using sign language with all children
- learning to listen

Topics Of Interest To Caregivers Serving Hearing Impaired Children

- encourage the use of residual hearing (auditory stimulation)
- how to read an audiogram
- meeting with hearing impaired adults
- learning sign language in depth (individual, videotapes, sign language course offered by community group or college)
- hearing aids
- integrating children with hearing impairments
- visiting the child's classroom

Suggestions For Speakers Or Consultants

- hearing education specialist from public school special education program
- hearing aid technician
- adult with hearing impairment
- sign language interpreter
- parent of child with a hearing impairment
- speech and language pathologist with experience with hearing impaired children

RESOURCES

Alexander Graham Bell
Association for the Deaf, Inc.
3417 Volta Place, N.W.
Washington, D.C. 20007
Phone: (202) 337-5220

National Association of the Deaf
814 Thayer Avenue
Silver Spring, Maryland 20910

Gallaudet College Press
Gallaudet College
Washington, D.C. 20002

American Speech-Language-Hearing Foundation
10801 Rockville Pike
Rockville, Maryland 20852

The John Tracy Clinic
806 W. Adams Boulevard
Los Angeles, Cal. 90007

Some communities have sign language clubs that get together periodically for "signed meals" or other such activities to help members get more sign language practice. Try contacting agencies serving disabled or other providers of services to the hearing impaired to find out if there is one in your area.

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Sign language courses may be available through:

- colleges or universities
- park districts
- adult education programs
- agencies serving the disabled
- centers for independent living
- speech and hearing clinics

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Meadows, K.P., *Deafness and Child Development*, Los Angeles, CA: University of California Press, 1980.

Northcott, W.H., ed., *I Heard That! A Developmental Sequence of Listening Activities for the Young Child*, Alexander Graham Bell Association for the Deaf, Inc., Washington, DC, 1983.

Ogden, P.W., and Lysett, S., *The Silent Garden*, St. Martin's Press, New York, 1982.

Vaughan, P. ed., *Learning to Listen, A Book by Mothers for Mothers of Hearing Impaired Children*. Beaufort Books, Inc. New York, 1981.

Ward, M.J., Arkell, R.N., Dahl, H.G., and Wise, J.H., *Everybody Counts! A Workshop Manual to Increase Awareness of Handicapped People*, The Council for Exceptional Children, 1971.

SAMPLE RESOURCE SHEET

Age of Child: 0 - 3

Special Need: Patsy is a twelve month old girl with "profound bilateral hearing loss" (she is deaf in both ears). She is just beginning to wear one hearing aid. Patsy seems to have normal intelligence. She is delayed in her gross motor development and is just learning to pull up on furniture.

IFSP Goal: Patsy will wear her hearing aid during all her waking hours.

Objective: Patsy will wear her hearing aid for one hour without removing it.

Suggestions/Adaptations:

1. Make sure that parents have done the daily hearing aid check and that Patsy is wearing her aid when she first arrives at day care.
2. Praise Patsy for wearing her hearing aid.
3. If Patsy removes her aid, immediately put it back in her ear.
4. If needed, try having Patsy wear a specially adapted bonnet that makes the aid less susceptible to removal.
5. Make sure that Patsy (or any of the other children) does not remove the battery from her hearing aid as swallowing it could be dangerous.

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SAMPLE RESOURCE SHEET

Age of Child: 3-5

Special Need: Joshua is a four year old boy with a history of intermittent conductive hearing loss as a result of middle ear fluid build up caused by repeated ear infections. Joshua also has serious articulation problems.

IEP Goal: Joshua will pay attention to stories during group times.

Objective: Joshua will be able to tell three details from a story on request.

Suggestions/Adaptations:

1. Make sure that Joshua can hear by having him sit in front at group time.
2. Read the story in a small group rather than a large group (divide the group in half for story time).
3. Encourage active involvement in the story by asking questions from time to time.
4. If Joshua's self esteem is low as a result of his articulation problem, try having him draw a picture or pictures depicting events in the story.
5. Have Joshua listen to a story on tape using headphones.

SAMPLE RESOURCE SHEET

Age of Child: school-age

Special Need: Calvin is a nine year old boy with a moderate to severe bilateral sensori-neural hearing loss. He wears hearing aids in both ears which improves his hearing somewhat. Calvin uses sign language in addition to lipreading and the use of his residual hearing (total communication). He is learning to talk, but he is difficult to understand.

IEP Goal: Calvin will be able to communicate with the other (hearing) children to a degree that it is not frustrating for both.

Objective: Calvin will be able to communicate with friends while playing a sport outdoors.

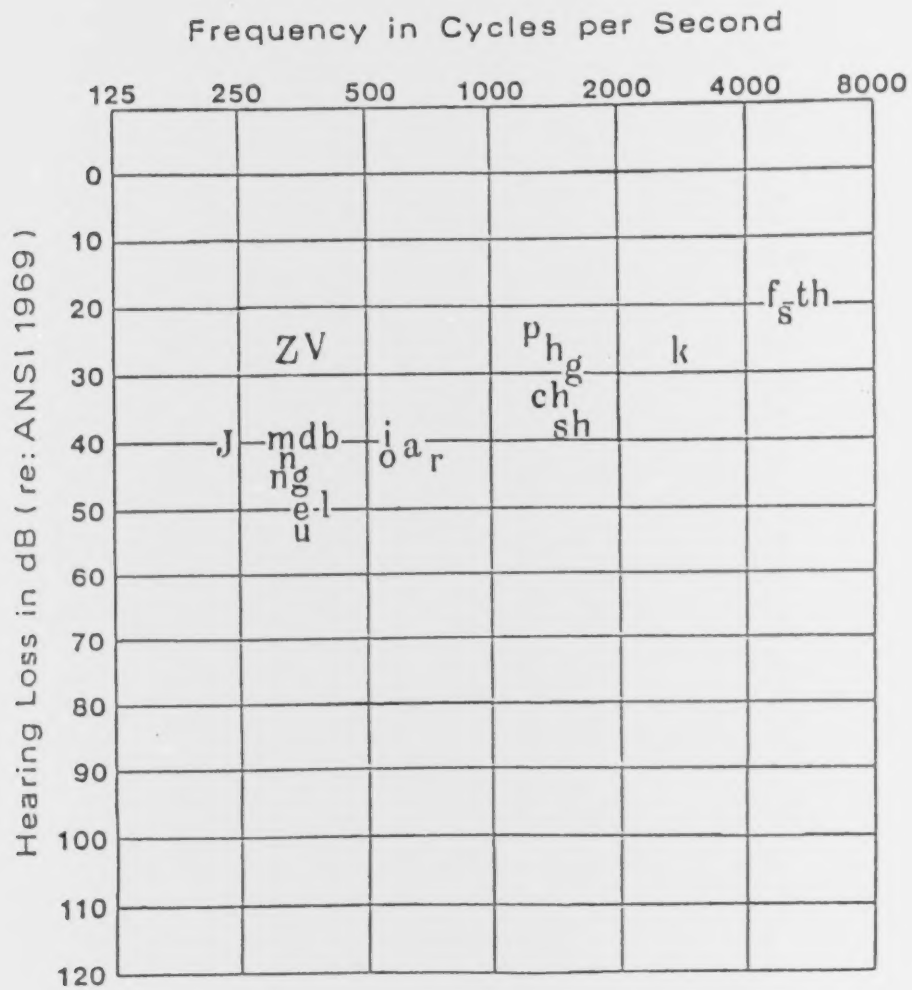
Suggestions/Adaptations:

1. Teach (or have Calvin teach) all the children in the after-school program some crucial sign language, especially signs related to playing the games that Calvin likes. Show the children how this can be used easily outdoors. Consult Calvin or his parents or teacher for the specific signs that they use.
2. Make a sign language dictionary available for all the children to use at any time.
3. Be especially careful when you talk to Calvin on windy days as the wind blowing over a hearing aid microphone interferes with the ability to hear other sounds.
4. Make the environment both inside and out as visual as possible.
5. Give Calvin a listening buddy for outdoors to help him hear warnings (such as when a ball is going to hit him in the face!) and know when it is time to go in (if the teacher uses a whistle).

Handouts and Supplementary Materials



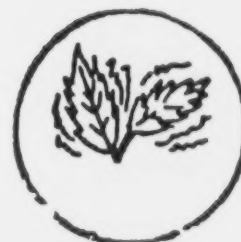
FREQUENCY SPECTRUM OF SPEECH SOUNDS



SOUND LEVELS IN DECIBELS

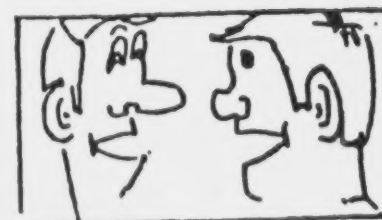


Soft whisper (5')----



30---Private business office

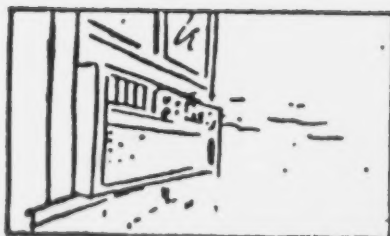
Vacuum cleaner (10')---50---Conversation (3')



Car accelerating (50')---60---Inside car at 50 MPH

Motorcycle (50')---70---Snowmobile

DC-6 Airliner (inside)---80



90

Automobile horn (3')---100---Rock and roll band
Chain saw (50')

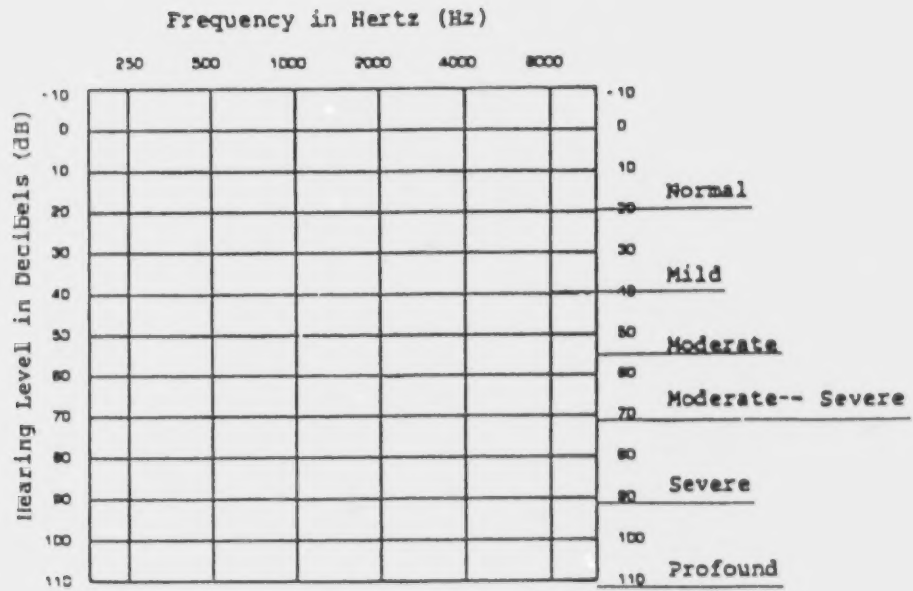
110---Jet plane (50')



Threshold of pain---120---Hydraulic press (3')



DEGREES OF HEARING LOSS





Central
Association
for Special
Education

2240 East Geddes Avenue • Decatur, Illinois 62526
(217) 424-3420

UNDERSTANDING MIDDLE EAR INFECTIONS

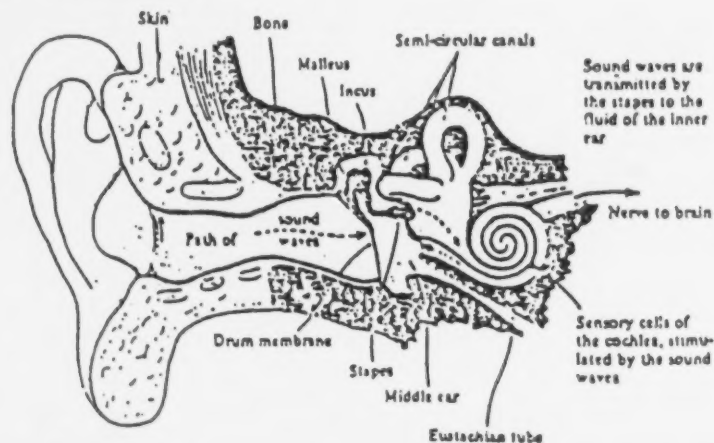
THE EDUCATIONAL IMPACT OF MIDDLE EAR INFECTIONS

Ear infections, particularly those in the middle ear, are the most common cause of acquired hearing loss in American children today. Hearing experts believe that many learning disabilities stem from the aftereffects of ear infections that go undetected during a child's preschool years. In these early years, a child is most vulnerable to distortion of sounds because he or she has minimal exposure on which to base comparisons.

Even a slight hearing loss can hamper a young child's ability to acquire the complex skills necessary to filter out background noises, combine sounds, discriminate between similar sounding words, and remember sequences of sounds. Later, a hearing loss can cause a youngster of normal intelligence to seem inattentive or "dull" in the classroom.

Because the degree of hearing loss can fluctuate as the infection flares and subsides, the problem can continue undiagnosed despite mass pure-tone screening conducted in many schools.

WHY ARE EARS PRONE TO INFECTION?



Because the ear is a complex mechanism in a small space, minor irritation or swelling can significantly impair hearing functions.

The external ear consists of the outer "auricle" of cartilage and the ear canal. The auricle helps direct sound waves inward. The ear canal extends about an inch into the head and ends at the eardrum, a membrane only 1/250 inch thick. Behind the eardrum is the middle ear, an air-filled cavity that contains a chain of tiny bones that amplify and transmit vibrations. The fluid-filled inner ear converts vibrations into electrical impulses that are transmitted to the brain. Balance organs are also located here.

HEARING HEALTH CAREDOES YOUR BABY HEAR?

The symptoms listed below may result from other physical conditions or in combination with a hearing loss. Whatever the situation, we feel it is important for parents to be alert for any possible loss of hearing in a child or an infant. It is now possible to test the hearing of a newborn baby. By being alert, we hope we can detect hearing loss earlier and thereby give the child maximum opportunity to participate in the "mainstream of life".

Below is a simple test you might want to try:

	<u>YES</u>	<u>NO</u>
1. Does your newborn baby startle to a sharp clap within 3-6 feet?	_____	_____
2. Does your three month old baby stop moving or stop crying when you call him or make an unfamiliar noise?	_____	_____
3. Does your nine month old baby turn toward you when you call his name from behind?	_____	_____
4. Does your two year old identify familiar pictures (ball, baby, spoon)? Does he repeat words or phrases? Does he use short phrases in talking?	_____	_____
5. Is your child disturbed by loud sounds when he is asleep?	_____	_____
6. Does he turn when you call?	_____	_____
7. Does he pay attention to noises?	_____	_____
8. Does he use gestures to communicate?	_____	_____
9. Does your child get many colds or ear infections?	_____	_____

If your answer to questions one through seven is "NO", or your answer to questions 8 or 9 is "YES" then a hearing test may be indicated. If you suspect a problem, do BOTH of the following:

1. Take your child to his doctor for a complete examination.
2. Have an audiological evaluation by an audiologist.

NO BABY IS EVER TOO YOUNG TO HAVE A HEARING TEST

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Hearing Checklist:

The following may indicate a hearing problem:

- _____ turns body or head to speaker
- _____ watches speaker's lips
- _____ doesn't respond when back is away from (far away) speaker
- _____ doesn't respond when back is away from (nearby) speaker
- _____ restlessness, nervousness, irritability, or other unaccounted for behavior
- _____ poor sitting posture
- _____ body rigidity when attending to distant sounds
- _____ undue sensitivity to movement
- _____ tilting head to one side
- _____ tending to poke or pull at ears
- _____ closing or covering one ear
- _____ has allergies
- _____ frequent colds
- _____ says "what" frequently
- _____ asks for statements or questions to be repeated
- _____ frequent ear infections
- _____ talks unusually loud
- _____ laughs at inappropriate times
- _____ frequently answers inappropriately

by Christina J. Eckenstein, Central Association for Special Education

Audiometric Techniques

- Conventional - Person raises hand (usually) when tone is heard.
- Play - audiologist sits in same room with child and teaches them to put a block in a can when the tone is heard (or a similar task). Used often with pre-schoolers.
- Screened at dB HL - This is the softest level tested. For example if a child is screened at 10 dB HL and responds at all frequencies at that level he/she may actually hear better than that but softer levels were not tested. This is often done with children who have a short attention span.
- VRA - Visual Reinforcement Audiometry - Used with very young children either in the soundfield or with earphones. The child is taught that if he/she looks to the right (or left) after the signal is heard on the right (or left) he/she will be reinforced with some type of visual stimulation. This can be used with pure tones, warbled pure tones, narrow bands of noise, or speech.
- BOA - Behavioral Observation Audiometry - If the audiologist is unable to train a child for VRA then BOA may be used. The child's responses to various levels of stimulation are noted. This is not a very reliable test procedure.
- _____ - Other techniques noted - often NBN or WPT is indicated here if narrow bands of noise or warbled pure tones are used.

Speech Audiometry

EAR	Pure Tones	Speech Thresholds		Speech Discrimination			
	PT AVG 500-2000	SRT SAT	dB RE Masking	Quiet	dB RE Masking	Noise	Signal to Noise Ratio
Right		AC BC	AC BC	HL %	HL %	HL %	HL %
Left		AC BC	AC BC	HL %	HL %	HL %	HL %
SF							
Aided SF							
W22	Spondee Words	Speech Noise	W22	Speech Noise	W22	dB Ratio	dB Ratio
W22	Numbers	Speech Noise	W22	Speech Noise	W22	dB Ratio	dB Ratio
W22	Pictures	Speech Noise	W22	Speech Noise	W22	dB Ratio	dB Ratio
W22	MLV REC	MLV REC	MLV REC	MLV REC	MLV REC	MLV REC	MLV REC

PT Average -

Pure Tone Average - The average of thresholds at 500, 1000, and 2000 Hz. In some cases a 2 frequency average is used.

SRT -

Speech Reception Threshold - The quietest level at which a child can understand familiar speech. Usually spondee words (2 equally stressed syllables ie: baseball, hot dog, cowboy) are used. For a child with speech problems or young children they respond by pointing to a picture. Older children repeat the word back. (MLV - monitoring live voice - the audiologist said the words; REC - recording - a tape of the words was used).

SAT -

Speech Awareness Thresholds - The quietest level at which a child can detect the presence of speech. This may be 10 dB better (softer) than the SRT and is usually used only if the SRT can not be obtained.

dB RE Masking -

Masking is often used for speech audiometry as well- the level of masking is recorded here.

Speech Discrimination -

HL is the loudness level the words are presented; % is the percent of words the child was able to repeat back. If the test is done in quiet the score is listed under that heading. If the test is done with background noise (to stimulate a classroom) the score and ratio of signal to noise level is noted. The signal to noise ratio (s/n) is usually +9 or +10 dB. This means the words to be repeated are 9 or 10 dB louder than the noise. Words are often presented at 45 dB HL since this is the level of average conversational speech.

Impedance Tests

Impedance Audiometry:

These tests are used to evaluate middle ear function and the integrity of the auditory nerve. An earphone is placed on the one ear and a soft rubber tip is placed in the other. The initial part of this evaluation measures how well the middle ear and its mechanisms transmit sounds to the inner ear at various pressures in the ear canal. We are then able to determine if there is an abnormal condition in the middle ear. Loud tones will also be presented at the earphone. This test indicates how the inner ear and auditory nerve reacts to such sounds and is useful in locating any potential problem in the auditory system.

Tympanograms:

As air pressure changes the change in the middle ear is noted. On the tympanogram the higher the tracing the more middle ear movement has been noted. For sample tympanograms see the next page. The tympanogram will be the most meaningful part of the impedance results for you.

Reflexes:

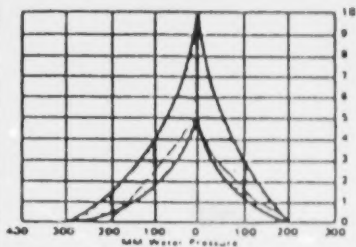
An acoustic reflex is a contraction of middle ear muscles following presentation of a loud sound. This is meant to protect the ear from the damaging effects of loud noise. Reflexes may be affected by some middle ear disorders and other disorders thereby making them absent (NR -no response).

Static Compliance:

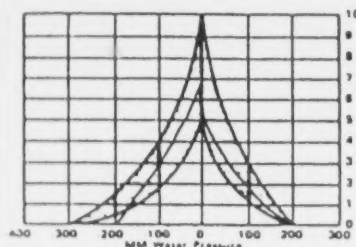
A measure of the stiffness of the middle ear system: i.e. eardrum and ossicles. An overly stiff or flaccid system can be an indication of a disorder.

IMPEDANCE TESTING - TYMPANOGRAMS

Right Ear



Left Ear

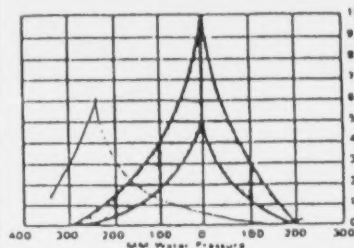


← Type A-
normal middle
ear mobility

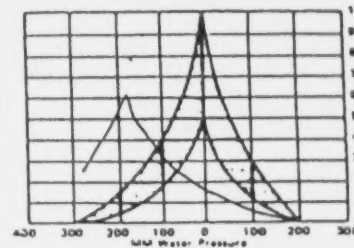
Reflexes					
Stimulus in	BSN	500Hz	1000Hz	2000Hz	4000Hz
Right Ear		90	85	85	80
Left Ear		95	90	80	80
NR is no response at dB HL.					
Static Compliance RE: .5 LE: .62					
Tubes:					

IMPEDANCE TESTING - TYMPANOGRAMS

Right Ear



Left Ear

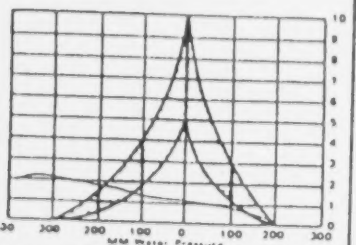


Type C-
drum retracted

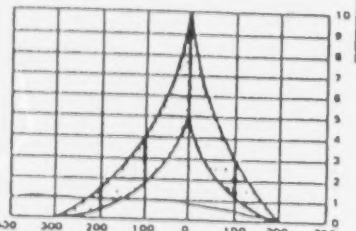
Reflexes:					
IPSILATERAL ☐ CONTRALATERAL ☐					
Stimulus in	BSN	500Hz	1000Hz	2000Hz	4000Hz
Right Ear		100	95	105	100
Left Ear		105	100	95	95
NR is no response at dB ☐ SPL ☐ HL					
Static Compliance RE: .6 LE: .6					
Tubes:					

IMPEDANCE TESTING - TYMPANOGRAMS

Right Ear



Left Ear

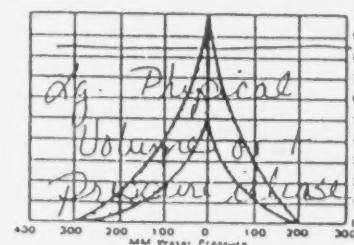


← Type B-
usually fluid
filled ear

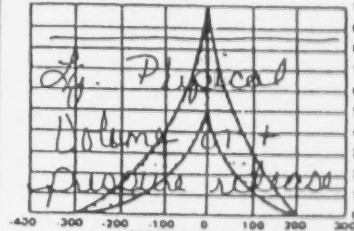
Reflexes					
Stimulus in	BSN	500Hz	1000Hz	2000Hz	4000Hz
Right Ear		NR	NR	NR	NR
Left Ear		NR	NR	NR	NR
NR is no response at dB HL. 110 dB SPL.					
Static Compliance RE: .2 LE: .1.					
Tubes:					

IMPEDANCE TESTING - TYMPANOGRAMS

Right Ear



Left Ear



→ Open Pressure
Equalization
Tubes

Reflexes					
Stimulus in	BSN	500Hz	1000Hz	2000Hz	4000Hz
Right Ear					
Left Ear					
NR is no response at dB HL.					
Static Compliance RE: LE:					
Tubes: At Physical Volume					

Other tests which may be performed, but not necessarily noted on the front of the audiological report are:

1. HAE - Hearing Aid Evaluation - Once a problem is located and the physician determines medical treatment is not indicated, we also provide hearing aid services. According to the child's particular hearing loss and other environmental and social factors several preselected hearing aids are adjusted to the child's needs. Several tests are then conducted in a sound treated room to determine which one is best. Hearing aid checks are also available to insure proper adjustment, operation and satisfaction at specified intervals.
2. EA - Electroacoustic Analysis - A sophisticated test of how well the child's hearing aid is working.
3. CAP - Central Auditory Processing Evaluation - An evaluation of children with normal hearing and usually of normal intelligence who nevertheless seem to have difficulty handling auditory information. A central auditory processing disorder can be considered to be an auditory learning disability. It may be associated with speech, language, reading difficulties, inconsistent behavior and poor academic performance. Please do not refer a child for a central auditory processing evaluation without first discussing it with the audiologist

This information is to help you interpret audiograms. If you have any questions please contact the audiologist for clarification. Also please do not hesitate to request the audiologist attend any conferences which will require that the audiological results be interpreted.

How to Read An Audiogram

AUDIOGRAM LEGEND

	AIR	BONE	AIR MASKED	BONE MASKED	NO RESPONSE	SOUND FIELD	SOUND FIELD (AIDED)
RE	○	<	△	⌈	↖	S	A
LE	×	>	□	⌋	↗		
CNE — Could Not Establish					DNT — Did Not Test		

Pure Tone Testing - This test is to establish your ability to hear very faint tones at various intensities (loudness), and frequencies (itches). These sounds may be introduced through earphones or a bone vibrator placed behind the ear. In some cases a noise may be placed in the opposite ear as a distraction to insure we are evaluating the ear which is under consideration (known as masking).

Audiogram - A graph of the quietest levels at which a child can hear tones of various pitches (frequencies). A child may be able to hear some frequencies better than others.

Air - Testing with pure tones through earphones.

Bone - Testing with pure tones through a bone oscillator (a vibrator placed on the mastoid bone just behind the ear).

Air Masked - Testing with pure tones through earphones with masking noise in the other ear (this makes sure only the one ear is being tested).

Bone Masked - Testing with pure tones through a bone oscillator with masking noise: the other ear.

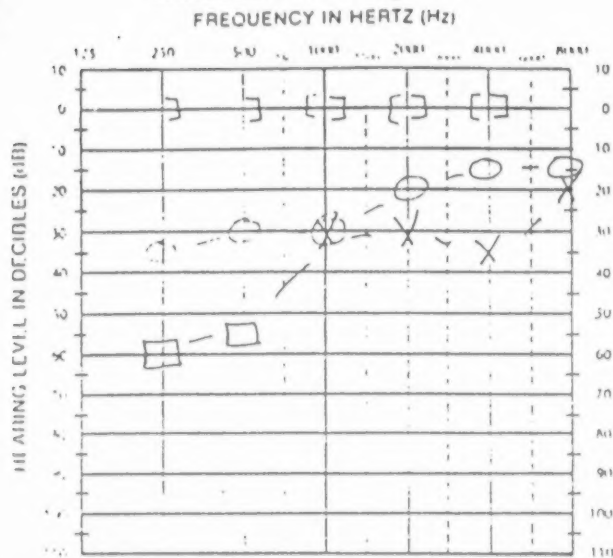
Soundfield - Without earphones - sounds are heard through the speakers. An "S" on the audiogram means the person responded to either a warbled pure tone or a narrow band of noise at that frequency and level.

Aided Soundfield - Testing with the hearing aid on in the soundfield.

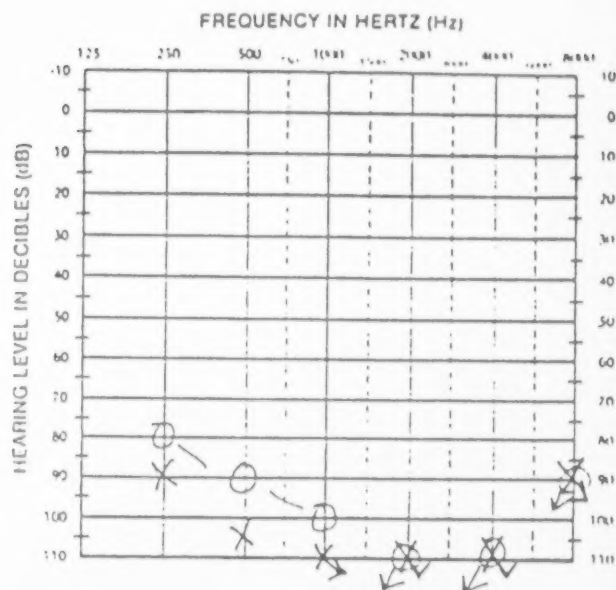
These symbols are plotted on the audiogram at the specific frequency (pitch) that was tested. The symbols placed at the lowest (softest) level the person was able to hear. On the graph 0 dB HL (top of the audiogram) is a soft sound and 110 dB HL (bottom of audiogram) is a very loud sound.

SAMPLE AUDIOGRAMS

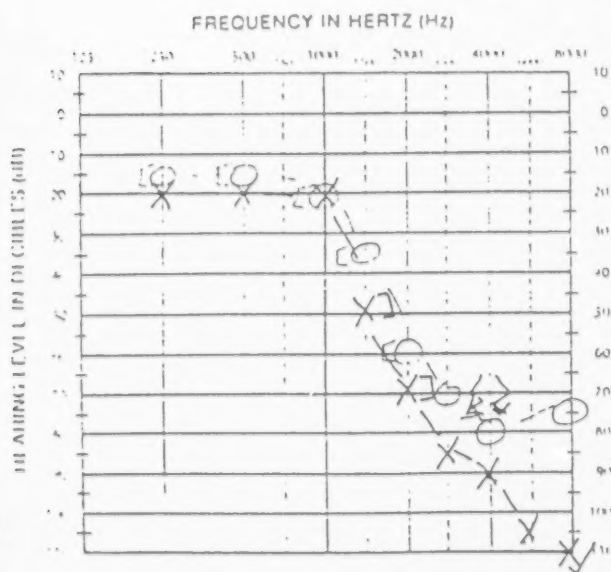
Conductive Hearing Loss



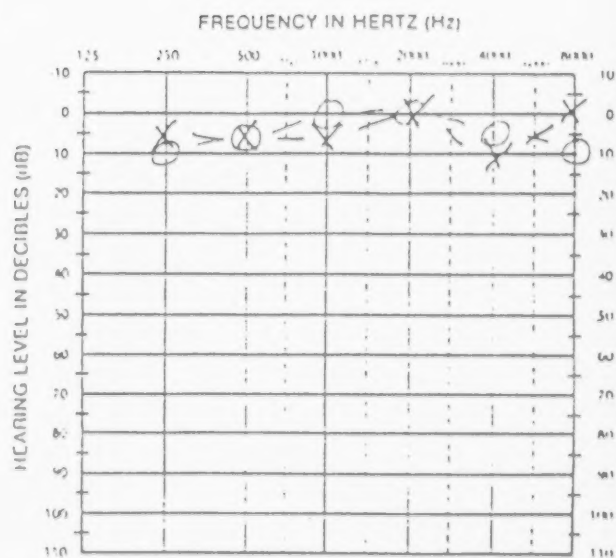
Profound Hearing Loss



Sensorineural High Frequency Hearing Loss



Normal



Central Association for Special Education Audiological Evaluation

Name _____
Address _____

Sex: M F DOB _____
School/Grade _____
City/County _____

Date _____
Site _____
Equipment _____
Audiologist _____
Referred by _____

AUDIOGRAM LEGEND

	AIR	BONE	AIR MASKED	BONE MASKED	NO RESPONSE	SOUND FIELD	SOUND FIELD (AIDED)
RE	○	<	△	□	↖	S	A
LE	×	>	□	□	↗		

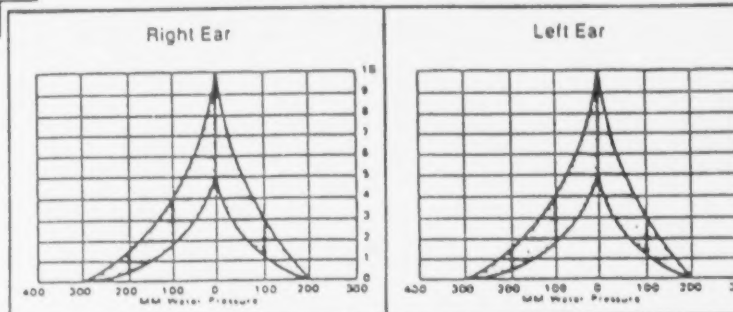
CNE — Could Not Establish DNT — Did Not Test

Test Reliability: _____

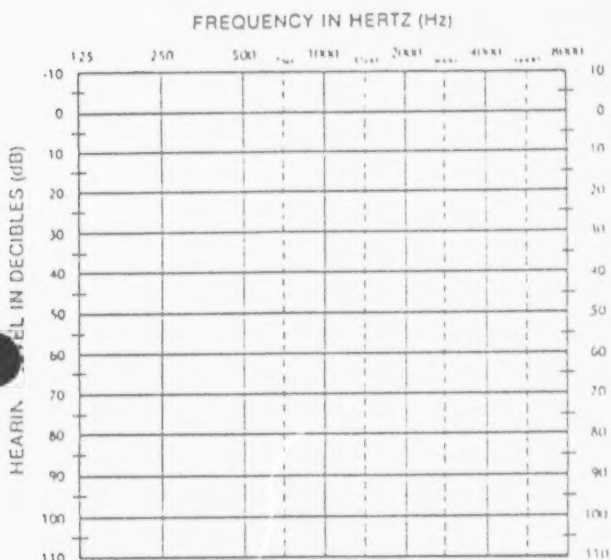
AUDIOMETRIC TECHNIQUES

- ☐ Conventional ☐ VRA
☐ Play ☐ BOA
☐ Screened at ____dB HL

IMPEDANCE TESTING - TYMPANOGRAMS



Reflexes:	IPILATERAL ☐		CONTRALATERAL ☐		
Stimulus in	BSN	500Hz	1000Hz	2000Hz	4000Hz
Right Ear					
Left Ear					
NR is no response at		dB	☐ SPL	☐ HL	
Static Compliance		RE:	LE:		
Tubes:					



Air							
Bone							

EFFECTIVE MASKING RE OdB HL Narrow Band Noise

OTHER INFORMATION

SPEECH AUDIOMETRY

EAR	Pure Tones	Speech Thresholds		Speech Discrimination			
	PT AVG 500 2000	SRT SAT	dB RE Masking	HL	dB RE Masking	HL	Signal to Noise Ratio
Right		AC	AC	HL	dB RE Masking	HL	Signal to Noise Ratio
Left		AC	AC	HL	dB RE Masking	HL	Signal to Noise Ratio
S.F.							
Aided S.F.							
WPT	☐	Spondees ☐	Speech Noise ☐	W22 ☐	Speech Noise ☐	W22 ☐	4 Talker ☐
NBN	☐	Numbers ☐	White Noise ☐	PKB ☐	White Noise ☐	PKB ☐	Babble ☐
		Pictures ☐	White Noise ☐	WIPI ☐	White Noise ☐	WIPI ☐	Speech Noise ☐
		MLV REC ☐		MLV REC ☐		MLV REC ☐	

HEARING AID(S)

Make _____
Model _____
Serial _____
Ear _____
Receiver _____
Volume _____
Tone _____
MPO _____
Earmold _____
Earhook _____
Filter _____

GENERAL POINTS ABOUT AMPLIFICATION

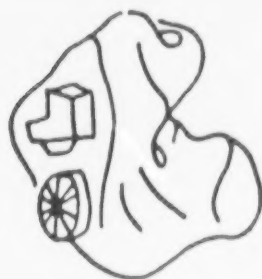
The results of the audiological evaluation suggest that a hearing aid will help your child. However, you should realize that a hearing aid will not make your child's hearing normal.

1. What your child hears will be distorted even with a hearing aid. It will make what your child hears louder but not clearer.
2. Sounds heard through a hearing aid may not have a natural quality.
3. A hearing aid will not only make speech louder, but background noise will also be made louder.
4. Since amplified sounds are directed to only one ear, your child could have difficulty localizing some sounds. In other words, he/she may have difficulty telling from which direction a sound came.

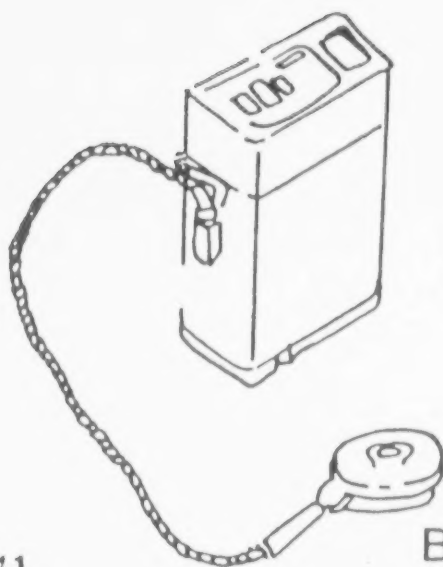
Even with the hearing aid, your child may miss some of what is said. The following suggestions may help your child better understand what is said to him/her.

1. When talking to someone with a hearing aid, you should face the person at a distance of no more than 4-5 feet.
2. Background noises should be kept as quiet as possible.
3. The child should be able to easily see the face of the person speaking.
4. The child should sit so that the ear with the hearing aid is closer to the person speaking. The child's aided ear should face away from such distracting noise as the television, radio, fan, open window, or hallway.

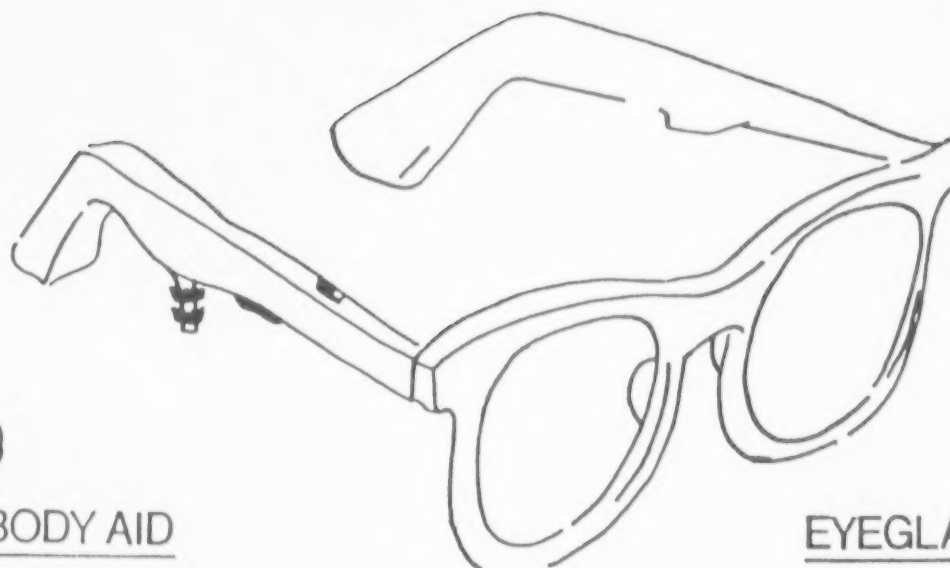
IN-THE-EAR



BEHIND-THE-EAR

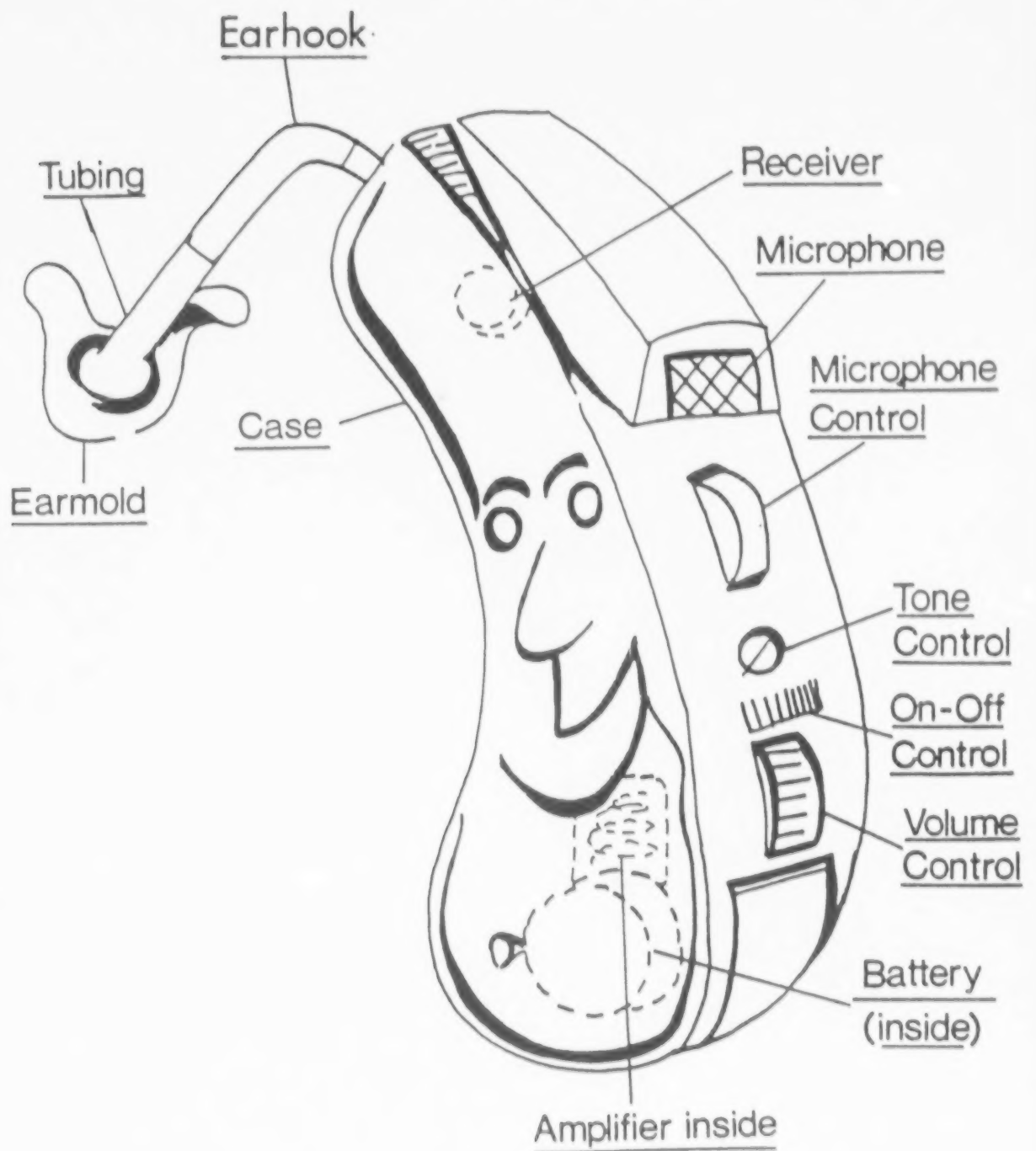


BODY AID



EYEGASSES

Behind-the-Ear Hearing Aid



MAINTENANCE AND CARE OF BEHIND-THE-EAR HEARING AIDS

The child's parents bear the major responsibility for answering that the hearing aid is functioning properly at all times. Caring for a hearing aid does not need to be complicated or time consuming if it is done on a regular basis.

HEARING AID

Dry -- Keep the hearing aid dry. Do not allow the hearing aid to be worn in the shower, when swimming, or in a heavy rainstorm. If the aid gets wet remove the battery and drain any excess liquid, wipe it clean, and dry with a soft cloth. Do not put it in the oven, on a heater, or on the stove to dry. You can use cool (not cold) air from a fan or air conditioner to help dry out the aid. You can also buy silica gel to put with the aid in a tight jar. This will help keep it dry. Contact the hearing aid dealer or audiologist if it still does not work.

Normal Temperature -- Do not expose the hearing aid to excessive heat or cold. For example, do not keep in the car.

Clean -- Clean the aid with a dry soft cloth. Do not clean with soap and water, alcohol, or any other cleaning fluid. Do not open the hearing aid to clean it, just wipe off the case.

Be Gentle -- Be careful not to drop the hearing aid. When giving the aid a listening check, you may want to stand over a bed or soft chair in case you drop it accidentally. Keep the aid out of the reach of pets, especially dogs.

On/Off -- The hearing aid should be turned off before it is taken off. At night take the battery out. This will help the batteries last longer.

Warranty -- Find out the term of warranty when the aid is purchased. Be sure to have the aid checked by the hearing aid dealer or audiologist just before the warranty expires.

EARMOLD

Clean -- Wash the earmold at least once a week using warm soap and water. Remove the aid from the earmold. (Do not put the hearing aid in the water.) Use a pipe cleaner to get wax out of the opening. Set the earmold on a dry cloth and let it air dry overnight after it is washed.

Fit -- The earmold should fit snugly but not be uncomfortable. If the earmold is uncomfortable or you notice feedback (squealing), talk to the audiologist.

Tubing -- The tubing should be replaced every six to nine months. If the tubing becomes hard or yellowed it should be replaced immediately.

BATTERIES

Clean -- Only use clean dry batteries. If there is white powder on a battery rub it off with a clean soft cloth, then rub with a pencil eraser. If there is any leakage, throw the battery away and wipe out the battery compartment. You may need to clean the battery contacts with a pencil eraser.

Fully Charged -- Remove a dead battery and replace it with a new fully charged one. Keep extra batteries on hand both at home and at school since there is little, if any, warning that the battery is going dead. To help the batteries last longer keep extra batteries in a cool dry place. Also, keep them from touching other metal. (For example, do not keep batteries in your pocket with your change.)

GENERAL POINTS

Daily Checks -- The hearing aid should receive a visual and auditory check every morning (morning and afternoon for young children). A stethoscope for listening to the hearing aid and a battery tester can be purchased from the hearing aid dealer.

Independence -- As soon as possible teach your child to insert the earmold, change batteries, turn the controls to the proper settings, and to report to you when something is wrong with the hearing aid.

Warnings -- 1) If the life of your child's batteries suddenly gets shorter, contact your audiologist immediately. It is a possible indication that either the hearing aid is malfunctioning or a decline in your child's hearing has occurred.
2) If your child starts turning the volume of his/her hearing aid up, contact your audiologist immediately. This also may indicate either a malfunction of the hearing aid or a decline in hearing.

HEARING HANDOUT 12
HEARING AID DAILY CHECK LIST

Visual

1. With a body aid, the contact points at each end of the cord should be inserted in the openings in the receiver and the hearing aid.
2. Check the volume control for the proper setting.
3. Check the earmold for wax, cracks, chips.
4. Check the hearing aid case for cracks, loose screws.
5. Check the battery with a battery tester.
6. Check the battery and its compartment for corrosion.
7. Be sure the battery is inserted correctly, the positive and negative surfaces properly placed.
8. With an ear-level aid, check the plastic tubing for stiffness, pinholes, cracks.
9. Check the earhook for cracks, holes, loose connection.

Auditory (Use a personal earmold or listening stethoscope or hold the receiver of a body aid to your ear.)

1. Set the volume control to the level used by the child. Listen for distortion, static, or some type of internal noise.
2. Listen for distortion when speaking into the microphone.
3. Gently tap the aid on all sides to check for a reduction of power or loose connections. Check for loose screws in the case.
4. Slowly turn the volume control wheel up and down, listening for static, distortion, dead spots. The volume control wheel should not be too loose, or bind against the case.
5. Turn the "On-Off" switch back and forth to check for intermittent sound or loose connections.
6. If the aid sounds weak, insert a new battery. If the volume is still low, check with the dealer or audiologist.
7. To check for internal damage, turn aid off. With a body aid, remove the earmold from the receiver and place a thumb over the opening in the receiver. With an ear-level aid, place a thumb over the opening in the earmold which is still attached to the aid. Turn the aid on and the volume all the way up. Listen for a soft, whistling sound from the hearing aid case (ear-level) or the receiver (body) which may indicate an internal problem. Check with the dealer.
8. With a body aid, check the cord for intermittent signals, breakage, or loose connections by listening while wiggling the cord and rolling the cord between the fingers.

The hearing aid dealer or audiologist should be contacted if the following problems arise.

1. broken earhook
2. hole in plastic tubing
3. old, hard, yellow tubing
4. internal damage
5. broken hearing aid case
6. cracked or too small earmold

VISUAL NEEDS

What are visual impairments	page 20
How visual impairment affects the child	page 20
Identification and referral	page 21
Professionals who may be involved	page 21
Integrating the child with visual impairments	page 21
Suggestions for training	page 22
Resources	page 22
References	page 22
Sample resource sheets	page 24

Handouts and Supplementary Materials

Section V - Special Needs Modules

WHAT ARE VISUAL IMPAIRMENTS?

A child is generally considered to have a visual impairment if he has a vision problem that affects learning. Visual impairments cover a range and include children who are partially sighted to children who are blind.

Legal blindness is when a child has less than 20/200 vision in the better eye with correction. 20/200 means that the child sees at 20 feet away what the normal eye sees at 200 feet away on the Snellen Distance Eye Test chart. A child with 20/20 vision sees at 20 feet what the normal eye sees at 20 feet.

Legal blindness can also be diagnosed when there is a severe limitation in the child's visual field (less than 20 degrees peripheral vision). The child may have tunnel vision, have only peripheral (side) vision or have "spotty vision". Different visual field deficits lead to different functional disabilities. It is important to note that the majority of children who are blind do have some remaining vision.

Children with low vision may move closer to objects they want to see, have abnormal movements of the eyes, or tilt their heads to one side. A child with a severe visual handicap may shift weight from one foot to another, rock, flutter fingers in front of his face or turn his head more or less rapidly. These mannerisms could be mistaken for signs of other handicaps such as developmental delay. Also, many children who are partially sighted are overlooked and considered to be inattentive, unresponsive, or clumsy. It is crucial for the caregiver to be aware of changes in a child's appearance or behavior and note warning signals as soon as possible.

Consultants should find out as much as possible about the nature of the child's visual impairment and how it affects or could affect the child. Consult with the child's special service providers

to determine the following information:

1. What can the child see? Does he see better close up or far away? Can he see colors?
2. What is the child's visual field? Can he see better in front of him or to the side? Can he see better looking up or down?
3. Does the child have problems with glare?
4. How does the child's vision affect his ability to see print, small objects, or pictures in books?
5. How does the child's vision affect his mobility?
6. What kinds of adaptive devices can/should be used?
7. What is the best way to adapt common materials for use by the child?

HOW VISUAL IMPAIRMENT AFFECTS THE CHILD

Visual handicaps directly interfere with a child's ability to gain information through the visual channel and possibly interfere with the ability to act on that information. These children may be delayed in motor, self-help, speech/language, and/or social skills due to lack of exposure to variety of experiences. Children with visual problems may find their vision to be more problematic for one type of activity than for another. Children with a peripheral field loss (i.e. tunnel vision) would have more difficulty with mobility than with reading.

The time of the occurrence of blindness affects development in children. A child who is born blind (congenitally blind) may lag behind developmentally, whereas a child who is adventi-

Section V - Special Needs Modules

tiously blind (become blind after birth) may be developmentally similar to other children. It is important for the caregiver to know when the visual loss took place and have as much information as possible on the experiences and skills that the child has already had.

Blindness rarely occurs by itself. Most children with severe visual impairments usually have other handicapping conditions such as cerebral palsy or language impairments which are caused by varying degrees of brain damage. These other conditions make working with the visually impaired more difficult.

IDENTIFICATION AND REFERRAL

Since the caregiver is in a position to observe a child's behavior, she should become familiar with the following conditions that may denote a visual problem:

- crossed eyes
- red-rimmed or swollen eyelids
- red or watery eyes
- recurring styes (small inflamed swellings on the rim of the eyelid)
- crust near lashes
- constant blinking, squinting, or eye rubbing
- dizziness, headaches, or nausea
- holding objects too close or too far
- stumbles or trips over objects
- tilts head to one side
- does not recognize landmarks on familiar routes

PROFESSIONALS WHO MAY BE INVOLVED

Professionals involved with visually impaired children may include but are not limited to the following:

ophthalmologist- a physician who specializes in

the diagnosis and treatment of defects and diseases of the eye. A child who is suspected of having a visual problem should be referred to an ophthalmologist for testing and examination. An ophthalmologist is well-versed in the use of medication, glasses, surgery, and other types of treatment.

optometrist- a licensed, non-medical practitioner whose treatment is limited to the prescribing and fitting of glasses and contact lenses.

optician- makes and adjusts glasses for the wearer.

orientation and mobility specialist- teaches children to travel in and out of doors, adjust to new surroundings, and develop concepts that relate to body image and spatial awareness.

teacher of the visually impaired- has advanced training in teaching visually impaired persons. They evaluate and work with people in special schools, special classrooms, or home settings.

INTEGRATING THE CHILD WITH VISUAL IMPAIRMENTS

1. Include the child with visual impairments in all activities.
2. Encourage the child to move about his surroundings.
3. Feel comfortable using words such as "see" and "look".
4. Since the child with a visual impairment may not respond to many visual cues such as gestures, be sure to include verbal and tactile cues.
5. Identify boundaries inside and out by making children aware of their environment through the use of rugs, bookcases, grassy areas and familiar

Section V - Special Needs Modules

sounds. Attach patches of different textures to various "landmarks".

7. The child with a visual impairment should be told of changes in position of furniture and objects. Doors and cupboards should be all the way open or all the way shut, chairs should be pushed in, etc.

8. Encourage good posture and consult with a resource teacher for the visually impaired or an orientation and mobility specialist for assistance with poor posture or other mannerisms.

9. Provide space as needed for special materials and visual aids, such as large print books. It is important that the caregiver become familiar with any visual aid the child may be using. Again, the specialist or teacher for the visually handicapped can be of assistance.

10. Encourage the child to use his remaining vision.

11. Allow and encourage the child to experience textures, etc.

12. Provide concrete experiences through the use of objects and models.

13. Express yourself physically such as a pat on the shoulder, hand squeezes or a hug.

14. Use materials that utilize other senses, such as touch and smell.

15. Give the child the opportunity to move his body through space and develop muscle memory. Make use of obstacle courses.

16. Avoid shiny pages and shiny surfaces and select materials that have clear pictures and words.

17. Do not stand with your back to a window.

18. Extra time may need to be allotted for the child to complete a task.

SUGGESTIONS FOR TRAINING

General Topics

- identifying children with visual impairments
- care of eyes and vision

Topics of Interest to Caregivers Serving Visually Impaired Children

- information on specific types of visual impairment (egs. cortical blindness)
- stimulating vision in visually impaired children
- orientation and mobility
- choosing, adapting, and making toys for visually impaired children
- "blind mannerisms"
- environmental adaptations for visually impaired children
- mealtime with a visually impaired child

Suggestions for Speakers or Consultants

- a visually impaired adult
- teacher of the visually impaired
- orientation and mobility specialist
- deaf-blind specialist
- pediatric ophthalmologist
- occupational therapist who has had experience with visually impaired children

RESOURCES

Local school programs may have a teacher of the visually impaired who could provide training and technical assistance to caregivers. Hospitals sometimes have specialty clinics for children with visual handicaps. Some areas may have a university affiliated facility which provides direct services to children with handicaps and their families.

Section V - Special Needs Modules

The following is a list of associations and organizations that can be particularly helpful:

American Foundation for the Blind
15 West 16th Street
New York, NY 10011

Association for the Education of the Visually Handicapped
919 Walnut Street
Philadelphia, PA 19107

Closer Look
Box 1492
Washington, D.C. 20013

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091

Illinois School for the Visually Impaired
658 E. State Street
Jacksonville, IL 62650
217/245-4101

National Federation of the Blind
1800 Johnson Street
Baltimore, MD 21230
301/659-9314

Heart of Illinois Talking Book Center
845 Brenkman Drive
Pekin, IL 61554
1-800-426-0709

American Printing House for the Blind
1839 Frankfort Avenue
Louisville, KY 40402

Phillip J. Rock Center and School
818 DuPage Blvd.
Glen Ellyn, IL 60137
312/790-2474

Telephone Pioneers of America
Supervisor, Community Service Activities
195 Broadway
New York, NY 10007

Lions International
209 North Michigan Avenue
Chicago, IL 60601

REFERENCES

Corn, A.L. and Martinez, T., *When You Have a Blind Child in Your Classroom: Suggestions for Teachers*, American Federation for the Blind.

Groves, D., and Griffith, C., (1969), *Guiding the Development of the Young Visually Handicapped...A Selected List of Activities*, Ohio Department of Education.

Alonso, L., Moor, P., Raynor, S., von Hippel, C.S., and Baer, S., (1983), *Mainstreaming Preschoolers: Children with Visual Impairments*, U.S. Department of Health and Human Services.

Deiner, P.L., (1983), *Resources for Teaching Young Children with Special Needs*, Harcourt Brace Jovanovich, Inc.

Scott, E., James, J., and Freeman, R., (1977), *Can't Your Child See?* Baltimore, University Park Press.

Section V - Special Needs Modules

SAMPLE RESOURCE SHEET

Age of Child: 0-3

Special Need: Tracy is an eleven month old child who is severely visually impaired. She has had intervention from birth and can sit up and crawl.

IFSP Goal: Tracy will improve in her auditory awareness by attending to a toy with sound.

Objective: Tracy will move her head, reach out for, and crawl to a toy with sound.

Suggestions/Adaptations:

1. Use toys that will provide special interest for Tracy and develop more than one sense such as toys with texture or moving parts.
2. Make sure the toy continues to make sound until Tracy makes contact with it.
3. While working with Tracy, place the toy below, above and side to side to increase her reaching and range of movement.

SAMPLE RESOURCE SHEET

Age of Child: 3-5

Special Need: Steven is a four and a half year old boy who has some degree of visual impairment. He generally has good motor skills but is somewhat delayed in the area of language.

IEP Goal: Steven will make choices and answer questions that are posed by his caregiver.

Objective: Steven will retell a familiar story and answer questions about it.

Suggestions/Adaptations:

1. Choose stories that Steven really enjoys and is familiar with.
2. Encourage Steven to add his own interpretation of the story.
3. Use a pretend story to assist Steven in the development of what is real or pretend.

Section V - Special Needs Modules

SAMPLE RESOURCE SHEET

Age of Child: school-age

Special Need: Martha is a twelve year old girl who is legally blind. She does have some remaining vision mostly seeing varying shades of darkness and light. Martha is in a new after school program and is learning to find her way around.

IEP Goal: Martha will move freely about the building and ask for assistance when needed.

Objective: Martha will move about the corridors and her class and ask for assistance when needed.

Suggestions/Adaptations:

1. Encourage Martha to obtain her own materials and to move about the classroom. She should be told of any changes in furniture, objects, materials, etc.
2. If Martha requires the assistance of a sighted guide, she should grasp the guides upper arm just above the elbow to allow for ease of movement.
3. Martha should be taught to use the nearest student or adult as a sighted guide in the case of a fire drill. This alleviates problems of an assigned student being absent.

Handouts and Supplementary Materials





PARENTS ASK:
HOW DO I CHOOSE A TOY FOR MY BLIND PRESCHOOLER?

There are few special toys designed for the very young visually impaired child. Carefully selected commercially-available toys can provide learning opportunities for the visually impaired preschooler.

When you purchase a toy for your child, ask yourself:

Is this toy attractive and interesting? A child who cannot see will not be attracted by the visual aspects of a toy. Does the toy make a noise? Is it tactually appealing? Does the toy do something when the child plays with it? Many parents have found it helpful to close their eyes and try to experience the toy as their child will.

Is it adaptable? A good toy can be used in different ways at different stages of development. Multi-purpose toys enhance learning for many years. Blocks, wagons, or balls are appropriate for children of all ages.

Does it allow many opportunities for development? Through toys and play, visually impaired children can learn the elementary concepts which sighted children acquire incidentally. Choose toys that promote learning in all developmental areas -- toys which require the child to move the entire body; to use the small, muscles of fingers and hands; to use language; to interact with another child.

Is it safe? Toys should be sturdy and durable, with no sharp edges or breakable parts. A toy which is safe for a young child may not be safe for an older, stronger handicapped child who is developing at a slower rate.

Is it easy to handle? Size of a toy depends on the age of the child. For an infant, toys should be light in weight, small enough to be grasped, but large enough so that the child can't swallow it. Manipulative toys for a young child should be large; for an older child, smaller.

Is it easy to clean? Visually impaired children may use their mouths to explore objects longer than will a sighted child. Choose washable toys for the very young child.

Does it provide for sensory development? Multi-sensory toys will help the child to use the remaining senses. Toys for a child with some vision can be bright primary colors and have bold patterns. Choose toys which make different kinds of sounds, which differ in weight and touch, which have a distinct taste and odor.

Is it appropriate developmentally? Match the toy to the child, not by chronological age, but by developmental age. A good toy is challenging, but not frustrating, to the child.

The best "toy" for any child -- one that meets all the above criteria, is a caring adult -- you, the parent.

Donna Heiner
The International Institute for
Visually Impaired, 0-7, Inc.

MOTOR NEEDS

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MOTOR SKILLS

Caregivers need to know how motor development affects the young child as a whole. The caregiver may not understand the importance of the child's ability to move and to use his senses.

Children are included in this area when they have a condition which prohibits or impedes normal development of gross or fine motor abilities. Congenital anomalies (birth defects), accidents, or diseases may result in physical handicaps. Some examples of such conditions are physical or orthopedic impairments such as spina bifida, loss of or deformed limbs, burns which cause deformities, and cerebral palsy.

This category is more easily identified than some of the others, but there is still the possibility of inaccurate diagnosis. As a professional who sees children in a setting with others of the same age, caregivers will have a "feel" for what the movement of children looks like. Seeing a child actively moving around in a natural environment helps caregivers to observe things that others haven't observed. Often children with mild but significant motor problems do not get identified as soon as they could be. This is a concern because not being able to move normally may prevent them from learning through motor activities or joining peers in play.

NORMAL MOTOR DEVELOPMENT

Motor development, like other areas of development progresses in steps. Certain skills have to be learned before more complex skills can be attempted. It is important to be aware of the order in which motor skills develop in children. This kind of information can be found in developmental charts such as those included in the Identification Workshop. Knowing what to expect from children, and when to expect it, helps caregivers to provide opportunities for them to learn the

skills they need.

Motor skills follow certain patterns of development. Development proceeds from the head to the feet. First babies learn how to control their head and the areas near their head. Later, they develop control over their legs and feet.

Control of movement develops from the center of the body outward. Babies will learn to control their trunks before they learn to control their arms and legs. They will learn to control their arms and legs before they can learn to control their hands and feet.

Growth also develops from whole body movements to isolated body movements. When a baby first begins to reach for an object, you will notice that a lot more moves than just his/her arms and hands. His/her trunk and legs move a lot too. It takes awhile before they can move just the muscles they need to reach an object, without using the whole body. When a preschooler first tries to kick a ball, he will push his whole body into the ball. Later he will be able to keep his body still and just swing his leg to kick the ball.

Babies do not initially move themselves at will. They do not have conscious control of their movements. They react to their environment through reflex responses. All their crying and wiggling is not something they decide to do, any more than an adult decides to sneeze, yawn, or hic-cup. They simply happen without thinking. Even though the baby has eyes, ears, muscles, and nerves they cannot use them as adults can. Learning how to use them takes many years of effort. Children spend much time in their early years developing motor skills. Learning to control the head and trunk is one of the baby's first attempts to control his body. Sitting up involves developing strong muscles and also learning how to use the muscles. At first the baby sits in a slumped position. Later, the baby can sit

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with his back fairly straight although he tips over frequently because he has not learned to use his muscles well enough to keep his balance. Learning to walk follows the same kind of pattern. The muscles grow strong enough to hold the baby up, but he needs a lot of practice before he can walk without holding onto something. At about 1-year to 1-year and 3 months the child begins to walk. Climbing skills start to develop about the same time as walking skills. Many of the muscles needed in walking are also needed in climbing. Hand and arm control are important areas of motor development. Writing, drawing, sewing and working with almost any equipment, requires good hand and arm control. You have probably watched a baby working to reach a toy. It is not easy for him. After baby has learned to grab something with his hand, he must then learn how to let go of it. At first, he will rub the object against his body trying to pry it out of his hand. Later he will learn to release his grasp.

Caregivers of older children may wonder what this has to do with them. All of the basic movements that a human being will ever do, develop in the first year or so of life. The rest of the time is spent refining these movements. If a child is motorically impaired, he will be working on developing or refining the same skills as an infant or toddler. In some cases, the child will need to adapt or find an alternate skill to make up for one that he may never develop. For example, it may be impossible for a child with a spinal cord injury to learn to walk. He may work on skills that will enable him to move from one place to another in a different way such as rolling or wheeling himself in a wheelchair.

SENSORY INTEGRATION

Motor development begins with sensory integration. Caregivers may have heard this area of development referred to as perceptual-motor skills.

Sensory integration, simply speaking, is the ability to take in, sort out and connect messages from our body and our environment. We do this throughout our lives. A well organized sensory system is the basis for the child's future success in motor skills. The sensory integration system includes the following senses:

Tactile

Tactile refers to touch. We have two types of tactile systems in our body. One is called the protective system which alerts our body to potentially harmful or dangerous things. This is the system that is working when we accidentally touch a hot burner and immediately pull our hand away. The other touch system is the discriminative system. This gives us the ability to respond to the stimuli in our environment so that we can learn or gain information. Through this channel we can "feel" the difference between Daddy's rough beard and Mom's soft furry coat. It is necessary for these two systems to be balanced and work together.

Vestibular

The vestibular sense is located within the inner ear. This sense responds to body movement through space, and change in head position. It automatically integrates sensations from the movements of one's eyes, head and body. If this sense was not functioning well, it would be impossible for a child to look up at the blackboard and back down at his paper without losing his place. It would be difficult to walk along a rocky path without falling, or to balance on one foot long enough to kick a soccer ball. This same vestibular sense is central in maintaining muscle tone, coordinating two sides of the body, and holding the head upright against gravity. The vestibular sense can be thought of as a foundation for orientation of the body in relation to surrounding space.

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Proprioception

This gives us an awareness of body position. It is proprioception that makes it possible for a person to skillfully guide her/his arm or leg movements without having to observe every action. Proprioception also allows objects such as pencils, buttons, spoons and combs to be skillfully manipulated by the hand.

The other senses include the senses of smell, taste, vision, and hearing. Many times the tactile, vestibular and proprioceptive systems are not addressed but their importance to motor development is tremendous.

If a child is having difficulty moving his body, sensory integration activities should be done. Such activities can be suggested by the child's occupational therapist.

AREAS OF MOTOR DEVELOPMENT

Body Awareness

Body awareness involves knowing the names of different body parts, what they look like, how they are used and how they "feel" in different positions and movements. Children need a good concept of themselves. This concept grows as they gain more information about body parts, their uses, and care.

Gross Motor Skills

Gross motor skills involve the large muscles of the body. These skills include walking, jumping, hopping, throwing, climbing, kicking, etc. Developing gross motor skills is an important part of overall development.

Fine Motor Skills

Fine motor skills involve the small muscles of the body. These skills include moving your eyes to track an object, moving your mouth and tongue muscles to eat and speak, and using your hands

and fingers to draw, eat, button, etc. Helping young children gain control of their hands is a very important part of their experiences.

Strength

Strengthening individual muscles helps children develop new motor skills.

Balance (vestibular)

Balance involves the ability to resist outside forces such as gravity. It is used in change of weight distribution or resistance to someone pushing you. Standing or sitting up straight involves balance. Knowing and feeling how much "push" to give each of our muscles to keep our balance is a continuous yet unconscious task for all of us. Young children go through many growth spurts. Their weight distributions are always changing. As arms and legs get longer, they have to re-learn how to keep their balance.

Coordination

Coordination involves groups of muscles working well together. Most motor activities involve using many muscles at the same time. To do motor activities well, the muscles must work well with each other. The muscles need to know which ones "push", when and how much, and which ones to relax, when and how much. The more practice we get using muscles together, the more coordinated we become.

Mastery

Mastery means how automatic a skill has become. Practicing a new motor skill requires much concentration and thought. A child just learning how to jump a rope will think very hard about how he needs to move. After he has jumped the rope many, many times, he can do it with very little conscious thought. It has become automatic. He has mastered the task. Children who experience inordinate difficulty mastering new motor skills may have a problem with what is known as "motor planning", or praxis.

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TYPES OF PROBLEMS AND CAUSES

The child with motor disabilities can show a wide range of strengths and weaknesses. The motor disability itself can range from mild to severe. One child may seem a bit more clumsy than his classmates. Another child may have great difficulty with everyday tasks such as crawling, walking, reaching, holding an object, chewing, or moving his mouth and tongue for speaking. Many motor disabled children have normal intelligence. Others may have learning problems or other physical disabilities such as impaired hearing or vision. Whatever the problems, most motor disabled children can benefit from the integrated setting. There are many reasons why motor disabilities exist. Usually, there was some damage to the brain, nerves or muscles. Such damage can occur before, during or after birth.

Pre-natal damage occurs before the child is born. Possible causes are accidents, diseases, heredity, drugs used by the mother or malnutrition of the mother. Many, many times there is NO known cause.

Some babies develop normally but suffer damage during the birth process. Two of the most common injuries occurring during birth are anoxia and head injury. Anoxia occurs when the baby does not receive enough oxygen, which is essential for brain cells. A head injury may occur if the baby is very large, or the labor is very long during delivery.

Damage can also occur after birth. This may consist of high fevers, disorders such as muscular dystrophy, epilepsy, meningitis, broken blood vessels, seizures, accidents, burns, abuse, and exposure to severe cold which causes body processes to slow down.

Neurologic impairments also cause motor development problems. These are caused by damage to the brain, spinal cord, or nerves. Some condi-

tions that involve neurologic impairments include cerebral palsy, head injury, encephalitis or meningitis, spina bifida, back or neck injury, polio, diphtheria, and poisoning. Neurologic impairments can cause more than just a motor disability. Intelligence, the senses, and other areas can be affected as well.

Orthopedic impairments can cause motor delays. These are caused by damage to the bones, joints and muscles. Some conditions that involve orthopedic impairments include bone diseases, hemophilia, dislocation, arthritis, and muscular dystrophy. Orthopedic impairments do not usually result in other physical disabilities. Intelligence, the senses and other developmental areas are not usually affected.

POSITIONING

Positioning is used to place the child's body in proper alignment while he is engaged in everyday activities such as eating, sleeping, sitting or playing with toys. The purpose of positioning is to prevent permanent muscle or skeletal deformities, to facilitate the normal developmental sequence, and to keep abnormal reflex patterns from interfering with the child's ability to function. Proper positioning will also prevent skin breakdown and allow adequate circulation in severely involved children. For these children to participate in activities and learn, they need to feel comfortable and well balanced. The position of a child in each activity is your initial concern, so that the child can get involved in the activity. Examples of questions to ask include:

- Given some physical strengths and weaknesses of each child, where should the activity occur?
- In what position will each child have maximum freedom to see what she or he is doing and to move arms and legs?

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-How should each child stand? Freely? In a supported, stationary position?

-How should child sit? In a chair? Supported on the floor with material on lap or beside the child? In a wheelchair at a table?

-Should a child lie on one side? Lie on the floor with a bolster under the chest to free the arms and hands?

Whatever your decision, make sure that all children feel comfortable and well balanced. Otherwise, they will not be able to concentrate on the activity. Additional basic positioning techniques may be found at the end of the module. Also, you will find equipment suggestions helpful which may be found in the activity area of this module and at the end of the module.

IDENTIFICATION AND REFERRAL

Before referring the child to any person or agency, a caregiver must discuss concerns with the parents or guardians. Two handouts that can be used to identify motor problems are included at the end of this module.

A caregiver must have permission from the parent to refer a child for assessment. Most families have a family doctor, pediatrician, or health clinic to whom they entrust the medical care of their children. This may be a place to start. However, the child may also be seen by a physical therapist, occupational therapist, speech therapist, orthopedist and a person trained in special physical education. Other sources include your local school district or early intervention program.

Many times professional or parent associations can provide assistance. Such organizations may include your local or state chapter for the Council for Exceptional Children (CEC), the Easter Seal

Society for Crippled Children and Adults, the March of Dimes, and the Muscular Dystrophy Association, and the Division of Services for Crippled Children.

PROFESSIONALS WHO MAY BE INVOLVED

Caregivers should be introduced to the fields of physical and occupational therapy. They should know that a physical therapist (or PT) focuses primarily on the gross motor area, especially as it relates to sitting, standing, and location. An occupational therapist (or OT) does not prepare children for jobs. The OT focuses primarily on fine motor, self-help and adaptive skills, and sensory integration. Who does exactly what can be very confusing as there is a great deal of overlap with the two therapies.

Physical and occupational therapists are usually a great source of help. They are good at focusing in on specific advice on problems the caregiver is having and are very good at suggesting fun ways to facilitate development in a group setting. When a physical or occupational therapist is part of the child's program, he/she should be consulted before activities are suggested for the child. Most therapists are very willing to check over a list of adaptive activities for appropriateness for a specific child. They will often suggest additional activities or alternate activities which may be more appropriate for a given child. Video taping of therapy sessions is a great way for the caregiver to keep up to date with what a therapist is doing with a child. The consultant can tape a therapy session, and then show the tape to the caregiver at naptime or other convenient time. The session can be discussed as it is viewed and the consultant can address any questions. Session tapes can also be viewed in the caregiver's home and notes taken and discussed with the consultant or therapist at the next consultation

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meeting or day care visit. This can only be done if strict confidential measures are agreed to by the caregiver.

Cooperation and consultation with OT's and PT's can be facilitated in other ways beside videotaping. The day care program could provide release time for a caregiver to attend an actual therapy session. If it is not possible for the program to provide a substitute, the consultant could do this. Another way to facilitate cooperation between therapist and caregiver is for the therapist to visit the day care setting. At the very least, a caregiver and therapist can communicate by phone or through the consultant. The ideal situation is when all of these methods of cooperation/communication can be facilitated. Depending on the flexibility of the persons and programs involved, this may or may not be possible. Some programs have been able to do this in cases where it has been needed.

Children with motor impairments are usually seen by several kinds of physicians. The most common are pediatricians, neurologists, and orthopedists. Parents and written reports or medical records are the primary way we have of communicating with medical personnel. It is also possible to communicate by phone if necessary when permission is given by the child's parents.

SUGGESTIONS FOR INTEGRATING THE CHILD WITH MOTOR NEEDS

1. Allow any method for getting around in the setting (egs. a child might be able to crawl if he can't walk).
2. Provide only needed help. Unwanted help or help that is not needed is no help at all.
3. Make helping the motorically impaired child

a reward for the other children.

4. Use proper lifting techniques.
5. Make sure the room is free of obstructions and has a clear traffic pattern.
6. Be careful of loose rugs that the child could trip on.
7. Adapt materials to be wheelchair accessible if needed.
9. Carrying things can be a problem for the motorically impaired child. Provide him with a bag, basket, or buddy to help carry things.
10. Make sure the child is in a secure position when seated. Activities are difficult when the child has to spend all his energy keeping his sitting balance. The child's trunk should be in proper alignment and the feet should touch the floor.
11. Check field trip locations for accessibility.
12. Use alternate game pieces for the motorically impaired child. Small pieces in games may hinder the child's participation.
13. Choose activities that are open ended. Activities which have a specific product are often more difficult for the child with special motoric needs.
14. Allow the non-disabled children to try out any adaptive equipment used by the disabled child if it is alright with him and the equipment is sturdy enough.
15. Include dolls with impairments in dramatic play centers.
16. Include disabled models as part of the cur-

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riculum. Encourage visitors who are disabled to visit the program. Include posters and books that include people with disabilities. Be careful about using "token handicapped people or books". Have more than one book or one poster that depicts a person with a disability engaged in meaningful activity.

SUGGESTIONS FOR TRAINING

General Topics

- identifying children with motor problems
- setting up the environment to encourage motor development
- normal motor development

Topics for Caregivers of Children with Motor Problems

- adaptive equipment
- information on specific disabilities
- positioning and handling
- adapting games and activities to allow ALL children to practice
- information on adaptive equipment
- lifting techniques

Suggestions for Speakers or Consultants

- occupational and/or physical therapist
- recreational therapist
- adaptive physical education specialist
- parent of a child with motor problems

RESOURCES

The Arthritis Foundation
1212 Avenue of the Americas
New York, New York 10036

Closer Look
Box 1492
Washington, D.C. 20013

The National Lekotek Center
2100 Ridge Avenue
Evanston, IL 60201
708/328-0001

(see also all Illinois Lekoteks)

Muscular Dystrophy Associations of America
810 Seventh Avenue
New York, New York 10019

The National Foundation/March of Dimes
1275 Mamaroneck Ave.
White Plains, New York 10605

Great Lakes Resource Access Project
University of Illinois
Colonel Wolfe School
403 East Healey
Champaign, Illinois 61820

Spina Bifida Association of America
343 S. Dearborn, Suite 319
Chicago, Illinois 60604

National Association for the Physically Handicapped
76 Elm Street
London, OH 43140

Muscular Dystrophy Association
810 Seventh Avenue
New York, NY 10019

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SAMPLE RESOURCE SHEET

Age of Child: 0-3

Special Need: Marty is a two year old boy with a moderate form of cerebral palsy that makes his muscles weak. He is the only child in his day care class that is not able to walk. He is able to pull to stand and cruise around furniture. He receives weekly services from a physical and an occupational therapist.

I.F.S.P. Goal: Marty will learn to walk in the next 6 months.

Objective: Marty will let go of furniture and stand independently for a few seconds.

Suggestions/Adaptations:

1. Arrange furniture in the classroom to allow Marty to cruise as many places as possible.
2. When Marty is standing at a toy shelf or other piece of furniture of similar height, offer him a toy to encourage him to let go with one hand.
3. Avoid walking Marty around so much that he tires.
4. Provide Marty with a sturdy "walker wagon" (if he is ready). Make sure someone is with him as he is using this piece of equipment if he is not quite capable of letting go and getting to sitting easily. Make sure that Marty uses the toy in an area that is safe for the other children, as other children could get hurt if he bumps into them. A good place might be the gym or bike path where other children are using wheel toys.
5. When going on walks, take a stroller. Let Marty push it until he tires. Other children can take turns riding in it. A stroller is less likely to tip when someone is in it. When Marty gets tired, he can ride in it and the other children can take turns pushing him.

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VERY IMPORTANT!!!! *Make sure to consult the child's physical and/or occupational therapist before implementing suggestions for a motorically impaired child.*

SAMPLE RESOURCE SHEET

Age of Child: 3-5

Special Need: Allison is a four year old girl with spastic diplegia as a result of an intrauterine stroke. She is very tight on her left side. She walks clumsily with a pronounced limp. Allison has trouble doing activities requiring two hands. She is mildly mentally retarded.

I.E.P. Goal: Allison will spontaneously use her left hand to assist her right in two-handed activities.

Objective: Allison will hold down paper while drawing or scribbling.

Suggestions/Adaptations:

1. If it is too hard for Allison to do this activity at first, tape the paper to the table so she can achieve success and participate with the other children.
2. Provide lots of opportunity for Allison to play with toys requiring two hands such as pop beads, duplo blocks, bristle blocks, etc.
3. When playing in sand or water, make sure Allison uses both hands to explore the medium. If she doesn't, try gently nudging her left arm forward at the shoulder.

SAMPLE RESOURCE SHEET

Age of Child: school-age

Special Need: Maria is a nine year old girl with spina bifida. She walks with leg braces and a walker and has bowel and bladder control problems. She has normal intelligence.

I.E.P. Goal: Maria will upgrade her means of mobility from a walker to forearm crutches.

Objective: Maria will use crutches to walk a distance of ten feet.

Suggestions/Adaptations:

1. When Maria arrives at the door and gets her coat off, have her walk with the crutches to the snack table.
2. Allow Maria to continue to use her walker for long distances (egs. field trips).
3. Encourage Maria to walk short distances (2-3 feet) with only braces. Have other children close by in case she falls.
4. Allow the other children to examine or try out Maria's equipment if she agrees.

Handouts and Supplementary Materials



SUSPECT MOTOR SIGNS

1. **Unusually floppy:**
 - head control still poor at 3 or 4 months
 - easily slips through arms when picked up
 - "frog legs" posture past 4 or 5 months (legs in side abduction and flexion at hips)
 - general lack of movement compared with other babies the same age
 - very rounded back in sitting position
 - excessive W-sitting
 - no weight on legs past 4 months
2. **Unusually stiff or rigid:**
 - legs "scissor" when picked up
 - can't easily bend or separate legs to diaper
 - legs turn in, feet look "clubbed" (turned sharply in and down)
 - hands fisted past 4 months
 - shoulders stiff, one or both arms do not easily come forward for play
 - any arching or thrusting backward of neck and spine except when tantrumming
 - arching on back to move
 - walk on toes all the time
3. **Asymmetries:**
 - one hand never involved in activities, or strong hesitance to use it (dominance not usually established until >3 years)
 - "posturing" with one arm to side when moving or working with opposite arm
 - one leg turns in or out dramatically more than other
4. **Feeding Problems:**
 - tongue thrusting with spoon past 6 months
 - excessive drooling even when not teething
 - constant open mouth posture especially with head back
 - delayed chewing--can start to munch up table foods by 5 or 6 months, should be moving foods to sides to chew by 9-12 months
 - gags or chokes more easily than other kids
 - excessively fussy about new food tastes, temperatures, and textures
 - drinking with head back
5. **Prone Position:**
 - dislike of prone position for play at 3-6 months
6. **Unusual Sitting Positions:**
 - constant "W", unable to sit other ways
 - sits on sacrum
7. **Overly sensitive to touch, movement, sights, or sounds**
8. **Under reactive to stimulation (including head banging, oblivion to pain)**
9. **Fluctuation between these states (in 7 and 8)**
10. **Unusually high or low activity level**

11. Extreme impulsiveness
12. Extreme difficulty adjusting to new situations
13. Excessively clumsy, bumps into things, falls often
14. Extreme aggressiveness
15. Difficulty figuring out how to do a motor task

Any of the first six categories may signal a need for a referral for a developmental evaluation team which includes an occupational or physical therapist. the remaining items (7-15) may also be significant if several of these signs are present, or if seen in combination with more specific motor signs (1-6).

BEHAVIORS WHICH MAY INDICATE THE NEED FOR AN OCCUPATIONAL THERAPY REFERRAL

Gross Motor:

- Poor balance, trips or falls often
- Clumsy, bumps into objects or others, knocks things over
 - Difficulty maneuvering through obstacle course
- Attempts tasks in the same manner rather than try a new method
- Inappropriate posture when writing at desk
- Cannot sit or stand still
- Wraps feet around chair legs, lays on desk while working
- Dislike of ordinary playground or P.E. activities

Fine Motor:

- Poor motor coordination in writing
- Awkward manipulation of pencil, scissors, or small objects
- Difficulty coordinating both hands together
 - cannot clap to a rhythm
 - cannot catch a ball consistently
 - cannot tie shoes or button buttons
 - cannot skip in alternating pattern
- Non-dominant hand does not assist with activities such as not stabilizing the paper when writing
- Avoids crossing midline in general activities
- Presses too hard when writing, breaks lead often
- Sloppy appearance or work habits

Perceptual/Sensory Integration:

- Seems to know what he wants to do , but cannot "get it together"
- Poor organization of tasks
- Difficulty copying from blackboard
- Inability with puzzles that are not difficult for peers
- Cannot draw or match basic shapes
- Unable to stay on line when writing or tracing
- Problems with spacing
- Dislikes standing in line

SHOULD MY BABY HAVE A WALKER

Human babies follow a certain developmental pattern whereby learning head control leads to sitting balance, learning to sit alone prepares the child for creeping, and learning to creep prepares the child for walking.

Left to his own efforts a child will progress to walking when his body is ready to walk. A number of factors contribute to walking readiness. Baby's back muscles must be strong enough to keep him upright and balanced over his legs and feet. Baby must have developed certain balancing and protective responses which will protect him from serious injury during the many falls he will experience as he learns to walk.

Through creeping, Baby must learn to use his arms and legs rhythmically and alternately while holding his head up to see where he is going. The many small bones of Baby's feet are not hard like adult bones but are cartilage which is firm but flexible like hard rubber. The muscles which support the bones and which eventually hold the arches in place must be strong enough to hold the bones in good position when Baby stands on his feet.

Left to himself, Baby will creep and pull to a standing position. During this period he just stands with his feet fairly far apart and turned out for better balance. Later he will begin to sidestep while holding onto a support.

Baby needs lots of practice in all of the activities — creeping, balancing, standing — which strengthen his muscles, improve his balance, and lead to strong standing and walking positions. Walkers steal time from these essential readiness activities.

In a walker, Baby gets no stable standing practice. Any random leg movements push the walker from place to place. Rhythmic patterns of leg movement are not established and coordinated arm and leg movements fail to develop as they should.

A child who can move in a walker before he has balance — and judgement — can have a real adventure. Once in motion, he may not be able to stop, back up, or control the direction of the walker. Pediatricians report injuries from a tumble downstairs in a walker are common.

Baby will walk when Baby is ready. A fat, placid baby usually walks later than an active, wiry baby. Some children walk at 9 or 10 months. Others do not walk until 12 - 14 months. But one thing you can be sure of — given plenty of opportunities to creep, to pull to a standing position, and to cruise along supporting furniture, your Baby will walk when his body and nervous system are developmentally ready for walking. Babies enjoy walkers — but walkers take important time away from those developmental activities which produce real walking readiness.

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Dr. Robert Hannemann - Pediatrician
Dr. Miriam Bender - Physical Therapist, Ph.D.-Special Education
Drs. Joseph & Laurie Braga - Development Psychologists
Dr. George Early - Professor, Special Education
Dr. Liam Grimley - Professor, Educational Psychology
Dr. Phil Bach - Optometrist
Sylvia Kottler - Speech Pathologist
Dr. Bill Peterson - Certified Individual/Marriage/Family Counseling

Activities for Improving Sensorimotor Function

A. Body Awareness:

1. Identifying body parts, on self and on other people
2. Touching one body part to another, on command
3. Angels-in-the-Snow
4. Imitation of postures or body movements
5. The Twister Game
6. Kenner Sit N'Spin
7. Sand activities
8. Finger painting
9. Merry-Go-Round
10. Finger plays

B. Balance & Body Control:

1. Rolling
2. Somersaulting
3. Swinging
4. Teeter-tottering
5. Sliding
6. Pedaling tricycle
7. Riding scooter
8. Pulling & pushing wagon
9. Jumping
10. Hopping
11. Climbing
12. Activities on hands & knees:
 - Obstacle Course
 - Treasure Hunt
13. Animal Walks (duck, bunny, bear, seal, elephant)
14. Statues
15. Simple yoga postures - for children, not adults

C. Eye-Hand Coordination, Gross

1. Catching & throwing large ball (sitting or kneeling)
2. Throwing bean bags at a target
3. Fingerpainting - using large movements of arm
4. Fisher-Price Basketball
5. Batting games - using hand or large whiffle bat
6. Bowling game
7. Horseshoes or ring toss
8. Painting with a large brush on an easel
9. Stirring dough or batter with a mixing spoon
10. Self-help activities such as opening doors (turning knob), putting arms in sleeves, putting on slacks & shoes, washing hands & arms

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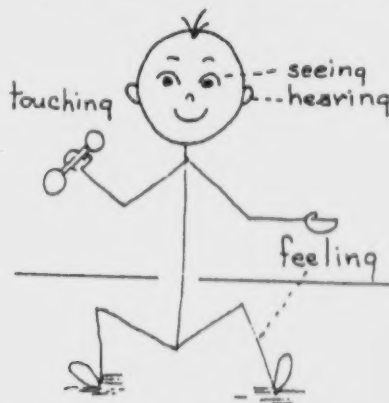
D. Eye-Hand Coordination, Fine

1. Lincoln Logs
2. Tinkertoys
3. Puzzles
4. Tupperware Ball
5. Playskool Lace Boot
6. 1" Blocks
7. Playskool Post Office
8. Play-Doh
9. Playskool Take-Apart Jeep
10. Child Guidance Take-Apart Tool Box
11. Playskool Workbench
12. Painting - using a sponge, vegetable prints, or an eye-dropper
13. Sewing Cards
14. Sorting dried beans, peas, etc. & putting them in pop bottles
15. Sorting nuts & bolts
16. Removing & replacing lids on empty jars
17. Tearing paper for collages; applying paste with fingers
18. Coloring within lines, using large designs with few details
19. Self-help activities such as buttoning, zipping, tying shoes, fastening hooks & snaps
20. Fisher-Price Record Player

SUGGESTIONS FOR HELPING MOTOR DISABLED CHILDREN

1. Provide many sensory activities.

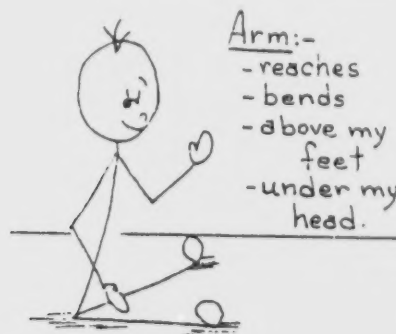
Often these children have trouble receiving accurate sensory information. He needs activities in touching, feeling, tasting, hearing and seeing.



2. Provide many body awareness activities.

Motor disabled children often have a poor concept of their physical image. Since the body is a frame of reference for many perceptual judgments, body awareness activities are very important. Provide activities in:

- a) Identifying body parts.
- b) Locating body parts.
- c) How they move.
- d) What they do.
- e) Their relationship to each other.



3. Provide mobility training.

Walking, crawling, rolling, bending, reaching and other movement activities are often taken for granted. "Getting around" is often a serious problem for motor disabled children. Provide activities and motivation to help these children develop their skills in movement.



4. Provide self-help activities.

The ability to care for yourself is essential in developing a good self-concept. Help children learn how to feed, dress, wash and take care of their personal needs. It will take more time and is often messy, but extremely important.



5. Consult a physical therapist or doctor for the best types of activities for this child.

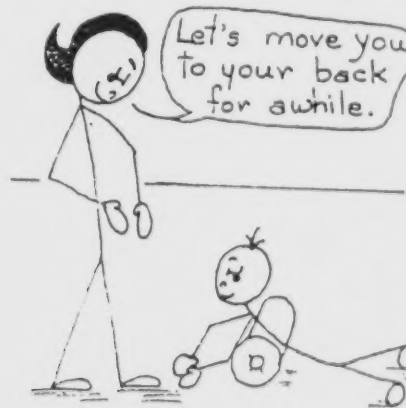
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6. Try to provide activities that give the child success.

Too many failures can make any child give up. Provide activities that meet the child's developmental level. Make them difficult enough to be challenging and exciting but easy enough for success.



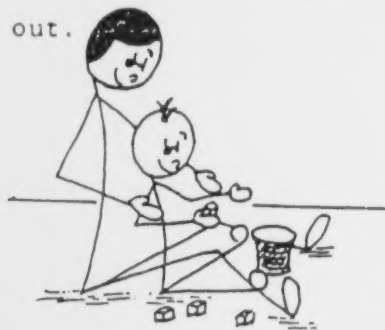
7. Provide both large and small muscle activities. The small muscles of the fingers, toes, mouth and face, are important to develop. The larger muscles of the legs, arms and body also need development.
8. If the child has very limited movement, be sure to change his position often.



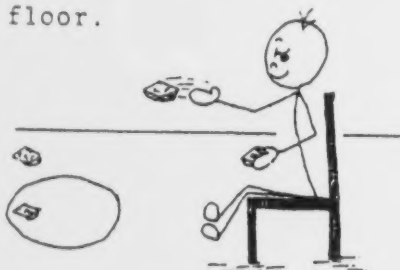
9. It is important that a child with motor difficulties be given the chance to discover for himself what he can and cannot do. He may fall or bump into things more often than other children. However, he must learn what his own abilities and limitations are.

Hand, Arm and Finger Development Activities

1. Have the child drop beads, blocks, etc., into a large container, and then take them out.



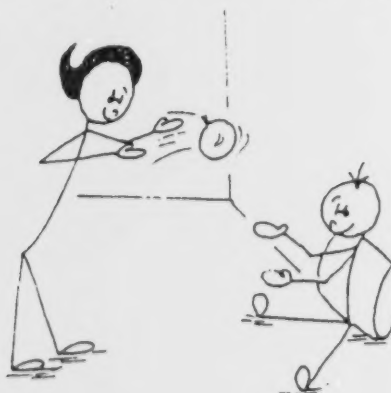
2. Have the child throw or drop bean bags into a large box or circle drawn on the floor.



3. Provide art activities, tear tissue paper, paste, finger paint, scribble and paint with a brush, etc.



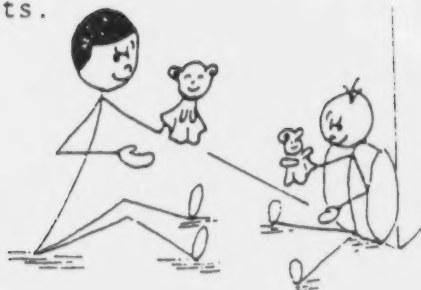
4. Toss a blown up balloon to the child and encourage him to hit it.



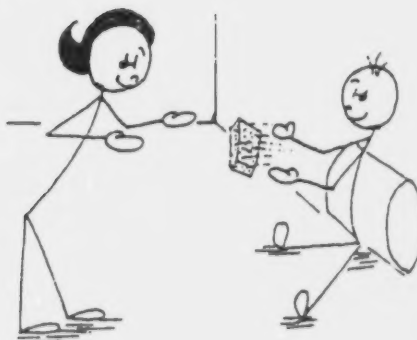
5. Have the child wave a scarf to music.



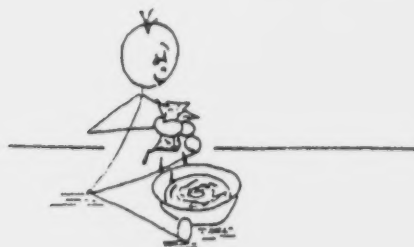
6. Use hand puppets.



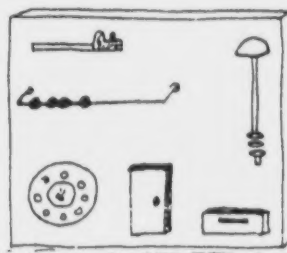
7. Toss sponges.



8. Squeeze water out of different sized sponges.

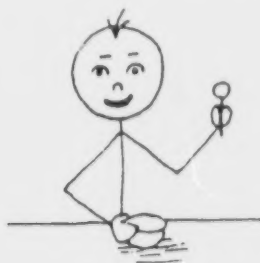


9. Put toys on the wall at the child's height. These wall toys can be bought or made. They can be used to exercise hand coordination. You might attach a board with different kinds of locks, latches, old telephone dials or put beads on a heavy cord or metal bar.



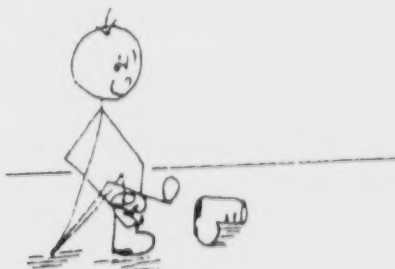
10. Practice feeding activities.

Feeding activities will help the child's hand-arm and finger development, as well as his self-help skills. Give them finger foods. Use a spoon spread with peanut butter or other sticky foods. Let them spread butter with a knife.

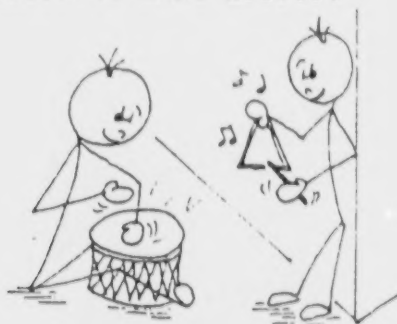


11. Practice dressing activities.

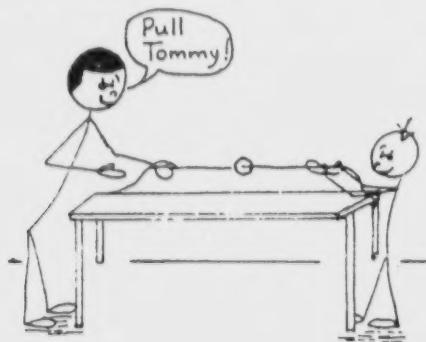
Teach the use of buttons, ties, clasps, zippers, etc. This helps small motor development and self-help skills at the same time.



12. Put a stocking over one of the child's arms. Encourage him to pull it off.
13. Encourage the child to put his arms in the sleeves of his coat or shirt. Start with a vest if sleeves are too difficult.
14. Practice washing and drying arms, face and hands with a wash cloth.
15. Use rhythm instruments, drums, bells, tambourines, etc. Encourage the child to make noises.



16. Play tug-of-war. Place a bead or ring in the middle and encourage the child to get it.



17. Play peek-a-boo. Gently cover the child's face with your hands or some cloth and have him pull it away.
18. Practice combing and brushing hair.
19. Try on hats.



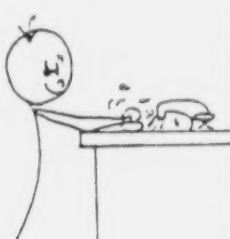
20. Work with play dough, bread dough or pudding.



21. Use finger puppets.

22. Practice putting on mittens and gloves.

23. Practice washing hands and rubbing lotion on fingers.



24. Use toy phones with dials and push buttons.

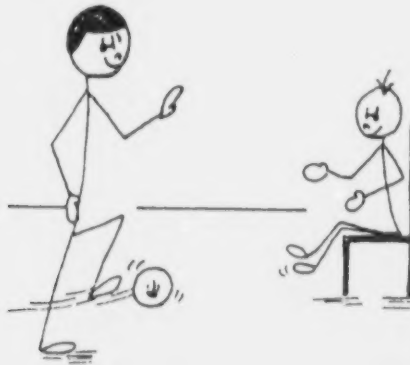


25. Practice finger plays.

26. Put scotch tape on child's fingers and encourage him to take it off.

Leg, Foot and Balance Activities

1. Seat the child in a chair. Place play dough in a plastic bag. Have the child flatten the dough with his feet.
2. Roll balls back and forth with feet.

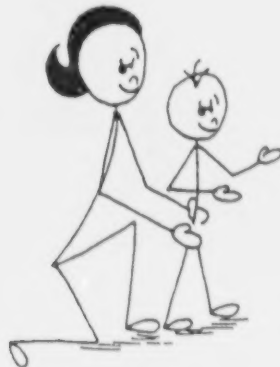


3. Provide several sizes of shoes and boots. Have the child try them on and move around in them.

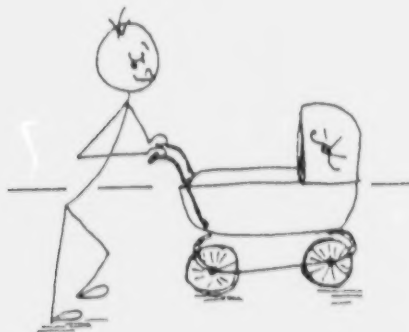


4. Put a finger puppet on a big toe. Encourage the child to wiggle his toe and move the puppet.
5. Put some clay or a crayon between the child's toe. Encourage him to wiggle his toes to remove the object.
6. Put bells or pom poms on the child's shoes. Encourage him to move them.

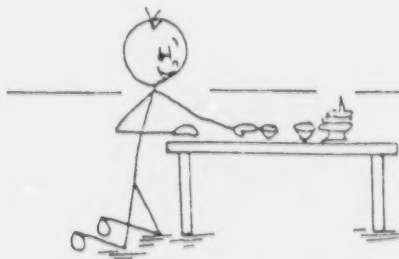
7. When working or standing, hold the child's hips instead of his hands.



8. Some children have difficulty walking because of poor balance or poor muscle control. It helps if they have something to push while they walk. A baby carriage filled with sand bags might be used.



9. If a child has not quite learned how to balance standing up, have him kneel up-right.



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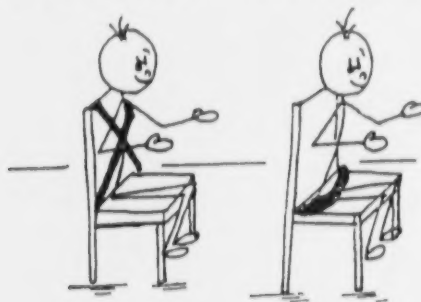
1. Chairs.

Some motor disabled children need side and back support when sitting.

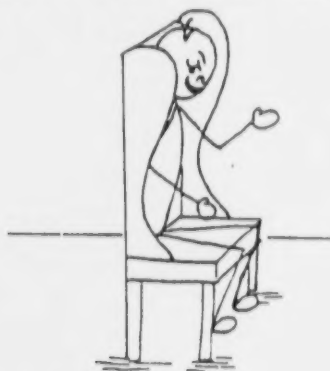
a) Use a tray or table.



b) Provide seat belts - shoulder or pelvis type.



c) Use chairs with sides added.



d) Use bean bag chairs.

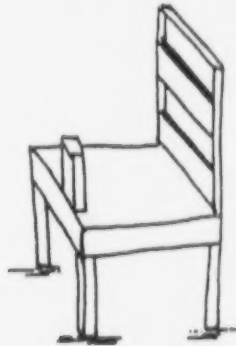


1. Chairs - continued.

The child's feet should always be supported when he is sitting. If a chair is too high, use a footstool.



A center support can be added to help children who slide off their chairs.



Don't use more support than the child needs. He needs to do as much on his own as possible.

2. Tables.

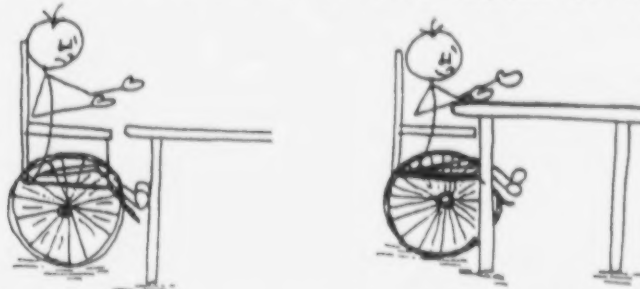
A chest high table can be used for trunk support for a child with poor trunk balance.



Children with weak shoulder muscles, usually do better having a table 1 to 2 inches below their arms.



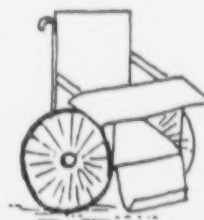
Children in wheel chairs should have tables of the proper height.



Semi-circular tables allow the child to easily pull into the table.



Trays can be used as table space also.



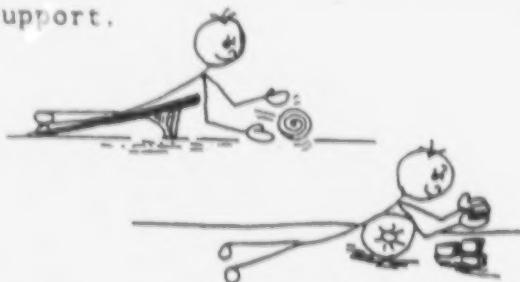
3. Use uneven surfaces like air mattresses, large pillows, floor mats, carpeted barrels, bolsters, inner tubes, beanbags, etc. This helps the child practice balance, coordination and gives an awareness of movement.



4. Use rocking horses and bolsters for rocking, straddling and balance activities.



5. Some children cannot support themselves enough to play in a face down position. Put them on an incline board or bolster for support.



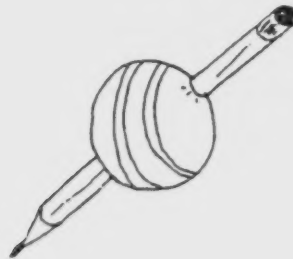
6. Large unbreakable wall mirrors are good teaching tools. Children can practice body identification, face and mouth exercises and self-help activities.



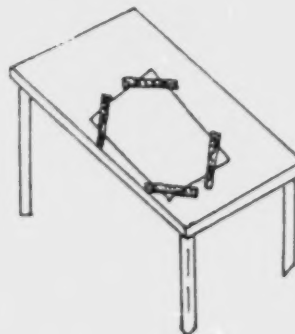
7. Metal and wood wall bars can help the child move around the room.



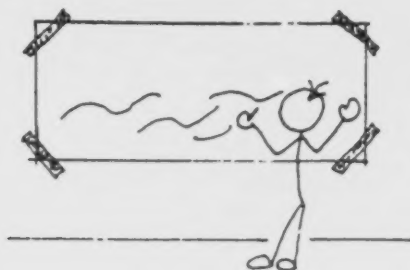
8. Push pencils through a small rubber ball or styrafoam ball, so the child can hold it easier.



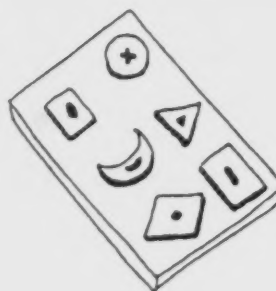
9. Wrap layers of masking take around the handles of spoons, forks, pencils, crayons, paint brushes, etc. This makes grasping easier.
10. Felt tip markers are easier to hold and require less pressure to make a mark.
11. Tape paper to the table to keep it from sliding around.



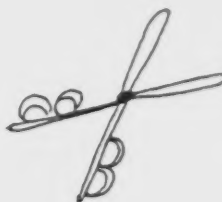
12. If a child can make only large sweeping strokes with his hands, avoid normal sized paper. It will frustrate him. Provide extra large paper, large blackboards, paper bags or cardboard boxes to paint and draw on. This will give him the room he needs.



13. Puzzles with knobs are easier for motor disabled children to use than the regular type.



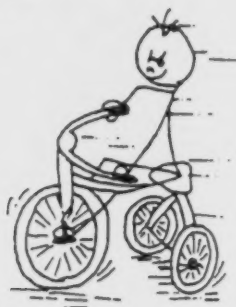
14. Spring loaded and double handed scissors are available to make cutting activities easier.



15. Velcrow can be used to replace zippers and buttons for easier dressing.

16. If a disability prevents a child from using a specific toy or piece of equipment, find a way to adapt it for him.

Suppose a child does not have enough motor control to keep his feet steady on the pedals of a tricycle. Secure his feet with a large rubber band made of a tire inner tube. It should be flexible enough so that the child can pull his feet out if he falls.



Teachers and parents can play an important part in helping children with motor disabilities. They can do this most effectively if they understand the nature and causes of the motor problems. Knowing what signs to look for and using special methods and equipment can do much to help these children develop to their greatest potential.

The Easter Seal Society For
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P.O. Box 2432, Anchorage, Alaska 99510

SPEECH AND LANGUAGE NEEDS

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WHY GOOD COMMUNICATION SKILLS ARE IMPORTANT

Good communication skills are important for the following reasons outlined by Erickson (1984):

1. It is how we let others know our feelings, ideas, and needs, and how we understand theirs.
2. It is the basis for complex thinking processes such as solving problems, remembering, abstracting, and acquiring new information.
3. It is what we use as part of our social skills.
4. It is the foundation for school success.

We use language to label, describe, give information, ask for things, actions, information, and permission, to promise, to apologize, to warn, to argue, to tease, to show humor, and to tell feelings. Communication skills affect all other areas of development such as thinking, planning, reasoning, paying attention, remembering, socialization, and self help skills. Caregivers need to recognize that a major part of learning is dependent on communication and the development of language.

INCIDENCE OF SPEECH/LANGUAGE IMPAIRMENTS

In most states, the largest group of children identified as having special needs is that with speech and language impairments. Caregivers should be aware that many young children classified as speech and language impaired are not categorized as such at a later age. The first reason for this is that, for a young child, language delay is often the only clear symptom of another condition such as mental retardation or learning disability. Because an accurate identification sometimes cannot be made for a young child, the child may be served as having a speech and language

impairment until a more specific diagnosis can be made later on. Secondly, speech and language is sometimes used as a category because some children are misidentified due to assessment difficulties. This is especially important to know in the case of children with hearing impairments who might be incorrectly identified.

Many kinds of special needs are often accompanied by speech and language impairments. Children with social/emotional difficulties, children with motoric or physical impairments, and children with hearing impairments often have special communication needs.

HOW CHILDREN LEARN LANGUAGE

As in other areas of development, language and speech abilities progress in a step by step manner. Stages may overlap, and the rate of progress may vary, but the sequence of development is the same. Children learn language by hearing it, by imitation, and by feeling the need to communicate. Some definitions may be helpful in understanding how children learn to communicate:

receptive language- the ability to understand ideas or feelings presented in symbols. These symbols may be words, gestures, sign, facial expressions, body language, or the written word. Receptive language comes before expressive language. Children need to understand language before they can use it meaningfully.

expressive language- the ability to communicate ideas, information, or feelings to others. Expressive language can be spoken or written words, gestures, sign language, etc.

speech- a system of vocal sounds used for communication (fl-ow-er).

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NORMAL SPEECH AND LANGUAGE DEVELOPMENT

A baby uses reflex sounds and gestures such as crying and head turning as his first language. Some caregivers (especially parents) can be very good at interpreting the meaning of a baby's cries. As the child gets older, he begins to use babbling sounds in place of crying noises. An example may be "goo goo ga ga". He also learns to understand simple words that are used often such as "bottle" or "Daddy". Young children often use gestures to "talk". A baby who does not want his food may turn his head to indicate his dislike. If a baby wants to be held, he may hold up his hands. The child also learns to imitate the rhythm and intonation of adult speech. After babbling, the child begins to use "jargon" which sometimes sounds like a foreign language to adults. As the child gets older, he feels the need to use more advanced forms of communication to express himself. He must first, however, understand what others are saying to him (receptive language). As the child learns to understand the meaning of words and sentences, he begins to build vocabulary. At first he may only imitate what he hears, with little understanding of what he is saying. He begins by using single words which he may intersperse in his jargon. As he begins to understand the meaning of words, he will usually begin to label objects meaningfully. He may then use single words to express a whole thought. For example, the word "Eat" may mean "I want to eat" or it may mean "The dog is eating". The single words are also used in a general sense. For example, all animals are "doggy". After the child develops a vocabulary of about 50 words, he starts to use two word combinations. These are combinations of words the child knows such as "Mommy go" or "More Baba". Between the ages of two and three, a child uses an increasing number of verbs and adjectives. At about age four, a child uses pronouns, connectives, and other parts of speech as adults use them. Later reading and writing become

important ways to understand and express language.

Caregivers often ask what a child should be saying at a certain age and how clear the child's speech should be. Caregivers serving children in similar age groups can compare children to each other. They should, however, take into account the difference in ages that may be represented in one group. Caregivers often think of the youngest child as "behind" the others. Caregivers need to have accurate information about the sequence of normal development and how to identify a child with possible delays. The reader is encouraged to refer to the "Identification" workshop for information on identifying possible delays. Included in the handouts for this module are examples of what caregivers should expect for children of different ages. It is important to keep in mind that children do develop at different rates and that there is a wide range of "normal".

IDENTIFYING AND REFERRING

To identify the child with speech and language difficulties, caregivers can be referred to the information on normal development described above and in the handouts at the end of the module. Caregivers should be encouraged to refer children they see with communication skills that are markedly different from other children of the same age. Referral is especially important if the communication difficulty is causing the child to have difficulty in other areas such as interacting with other children.

Referral sources will differ depending on the area in which the child lives. Caregivers should be provided with a list of sources in their area. Some examples of referral sources include birth-three early intervention programs, university speech and hearing clinics, hospital or clinic based programs, public school programs, private practitio-

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ners, etc. Caregivers like to have information on how to talk to parents about their suspicions. This information is provided in the workshop on "Identification". A sample referral source list is also included in that section. Make sure to discuss the issues of confidentiality.

PROFESSIONALS WHO MAY BE INVOLVED

The professionals most commonly involved with children with speech and language impairments are:

speech-language pathologist (speech therapist) works with children individually or in small groups to develop skills in using communication.

audiologist- assesses and monitors children for possible hearing problems that may be causing a speech/language impairment. May recommend hearing aides for children with identified hearing impairments (see Hearing Needs module for more on this).

Other specialists who may be involved are dentists, neurologists, otolaryngologist, pediatrician, and psychologist or social worker. Many of these are unfamiliar to the average caregiver. Who they are and what they do should be explained as needed. It is very interesting for caregivers to see how speech therapy is done. Most of us have the idea that speech therapy is when two people sit in front of a mirror and practice saying words. Viewing a videotape or sitting in on a therapy session is quite enlightening. Doing so will also encourage the caregiver to use language stimulation techniques with the children. De-mystifying a profession allows the caregiver to feel more competent to reinforce therapy goals, and to ask appropriate questions. The role of the audiologist is discussed further in the Hearing Needs module.

TYPES OF SPEECH/LANGUAGE IMPAIRMENTS

There are many types of speech and language problems. The most common are described below.

Receptive Language

Children with receptive language difficulties have trouble understanding what is said. They may not understand the meaning of words or the way words are put together. Following directions is especially difficult for these children.

Expressive Language

Children with expressive language difficulties have trouble expressing ideas verbally. They may not know many words. They may put words together in the wrong order (e.g. "Gome to school" or "We an running school".)

Articulation

Children who have articulation difficulties cannot clearly produce speech sounds. Speech sounds are the smallest parts of speech like "sss" as in "snake", or "mmm" as in "mom". It is important to remember that if a three year old says "fum" for "thumb", or "baftub" for "bathtub", they are using normal articulation skills for their age. But if a ten year old does the same, they would be showing signs of an articulation problem. In general, caregivers should be able to understand almost everything the child says by age four.

Voice

Children with voice difficulties have trouble producing speech sounds with correct pitch, loudness, and quality. Their voices may be too high, too low, too monotone, too loud, too soft, or any quality of voice that is distracting or unpleasant

Stuttering

Children who stutter speak with pauses or rapid repetition of sounds, words, and phrases. It is

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important to remember that between the ages of three and five, repeating words or phrases is normal. After age five, repeating is not normal, and this is called stuttering ("I w-w-w-want m-m-m-my ball!").

Auditory Processing

Auditory processing means having trouble receiving or problems organizing verbal language. This is different from a hearing loss. Sounds are heard, but not correctly understood. An example may be "the teacher told me to do something, but I can't remember what it is!"

Bilingual Environment

When children learn two languages at the same time, they should not be expected to be an expert in both. They have to learn how to say everything in two different ways. This takes longer. An example may be that "I have to remember 10 words to count to 10 in English" but "I have to remember 20 words to count to 10 in Spanish and English".

CAUSES OF SPEECH AND LANGUAGE PROBLEMS

Many conditions can cause speech and language problems. Some causes may be :

Hearing Loss

When a child is unable to hear well, learning language becomes extremely difficult.

Developmental Difficulties

If a child's growth and coordination are slow, his speech and language abilities might be affected. Delayed emotional development may cause a lack of interest in communicating. He may be afraid of failure. A mentally retarded child may not be able to understand the complex thought processes used in language. A child with motor development problems may have trouble mov-

ing his mouth and tongue properly for correct speech. Children with developmental delays usually show difficulties in all areas of growth.

Lack of Stimulation

Language and speech are learned. Children usually learn the type of speech their parents use. If a child is not regularly exposed to good language, he will have a harder time learning how to speak.

Deformity of the Articulators (mouth, lips, jaw, tongue, larynx, teeth, roof of the mouth)

These structures are used to produce sounds. When a deformity occurs, a child will have trouble making correct speech sounds.

Brain Dysfunction or Damage

The brain controls the many tiny muscle movements necessary for speech. The brain also controls a person's ability to receive, process, store and express verbal language. Certain misfunctions of the brain can cause speech or language problems.

Unknown Causes

Many times it is impossible to know the exact cause of a speech or language problem. Fortunately, treatment for speech and language problems can be very effective even when the exact cause is not known.

ALTERNATE COMMUNICATION MODES

Some children with special needs may need to use forms of communication other than the spoken word. There may be many reasons for this. Some children may be physically unable to produce speech. Some children will use alternate communication forms because spoken language may have little meaning to them (e.g. children with profound hearing loss). Some children use alternate forms of communication to facilitate

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the development of language skills in general. Many children with cognitive delays will learn sign language before spoken language because it is a more concrete symbol system than speech. The sign for eat looks like what a person does when he eats.

Alternate modes of communication include sign language, communication boards, communication books, symbol communication systems, and combinations of these modes. The combination of sign, spoken language, and any other form(s) of communication is called "total communication". Caregivers (and parents!) often ask why sign language (or any alternate form of communication) is used with children who can hear and might have the capacity for spoken language. They need to know that alternate forms of communication can be used as a "bridge" to spoken language. Sometimes children get the basic idea that objects and actions have labels by using more concrete forms of communication such as sign language. They learn that using these symbols makes something happen or someone pay attention to you. They are then able to generalize this skill to the use of spoken communication. Using alternate modes of communication facilitates rather than inhibits the development of spoken language.

Communication boards and books use written words or pictures of objects, actions, or people. The child points to the symbol of what he wants, thinks, or feels. Communication boards or books may be very simple or very complex depending on the language skills of the child. The simplest communication board may be composed of pictures of two commonly desired objects or toys. The child would point to or look at the picture of the object to choose what he wants to play with. More complex communication boards are computerized and produce a spoken word when the child touches a picture of a desired object. The most common communication boards or books

contain pictures of familiar people, activities, actions, foods, etc.

It is very important for the child using alternate modes of communication to have others who can communicate with him. Children can be easily taught to understand communication from a child using a communication board. Other children may want to make their own communication books to use with the child with special needs or any other children. Some groups have weekly sign language lessons or a "word of the week" to help in the learning of sign language by all children. Some schools are now offering sign language as an alternative to a foreign language class. Posters and books demonstrating signs are very helpful. Some family day care providers use the refrigerator as a makeshift "communication board". When teaching alternate communication to all children, parents should be encouraged to learn more about it also. The parents of all children may be concerned that their child's language development may be hampered.

SUGGESTIONS FOR INTEGRATING CHILDREN WITH SPEECH/LANGUAGE NEEDS

1. Use basic language stimulation techniques with the children. Examples of these include:

self talk- talking about what you are doing to give a verbal model to the child.

Example: "I'm putting the flour into the bowl".

parallel talk- talking to the child about what he is doing.

Example: "You're opening your book now."

expansion- in order to increase the length of the child's utterance, the child's statement is echoed so that new information is provided.

Example: Child- "I see a bear."

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Adult- "Yes, I see a big brown bear". younger children.

echo correction- in order to improve the quality of the child's utterance, the child's statement is echoed, but correctly.

Example: Child- "Me want cookie."

Adult- "Yes, I want a cookie."

Child- "Him has two cars."

Adult- "Yes, he has two cars."

stress change (focused stimulation)- putting emphasis on a word or language form the child tends to omit in a sentence but do not make him say it after you.

Example: "This is **my** coat." or "This is your **hattt**."

planned mistakes- purposefully make mistakes made by a caregiver to encourage the child to "notice" and make a correction. This technique works because children love to catch adults making mistakes.

Example: Adult- "I'm putting the **big** bear on the shelf."

Child- "No, that's the **little** bear."

modeling- caregivers should be good models of conversation and pronunciation. Modeling can also be used to demonstrate the correction of mistakes. In this case a "model" makes a purposeful mistake and the caregiver corrects him. The model can be another caregiver, another child, or a puppet.

2. When you talk to a child, make sure your language is appropriate to his developmental level. You should not talk to young children with language difficulties in compound sentences. Remember that a child cannot follow a direction he does not understand.

3. Teach language skills throughout the day. Use activity times to introduce new vocabulary. This is the same for older children as it is for

4. It is just as important for caregivers to listen as it is to talk. Make sure that the child's language has an effect. If he asks for something (and it is a reasonable request), make sure he gets it. If you cannot listen at a particular moment, tell the child that you cannot listen right now, but that you will in a few minutes. Make sure you get back to him.

5. Set up the environment to encourage communication. Provide opportunities where the child will have to ask for things he needs.

6. Try to reduce the amount of extraneous noise in the environment. Be aware of the acoustics of the room. Soft things tend to absorb sound. Carpet the backs of shelves (make one into a giant flannelboard). Make sure noisy areas such as block centers have (flat) carpet. Separate active and quiet activity areas.

7. Arrange for lots of opportunities for one to one talking. So when do you have a chance to incorporate one to one times? Think of what you can talk about in one minute! With infants, diaper changing times are ideal for one to one "conversations". With older children, the play-ground may provide opportunities for one to one talk.

8. Try letting the children deliver messages to other staff for you. Children in day care homes may be able to call parents at work occasionally.

9. Use a variety of printed materials to stimulate language. Don't limit yourself to books. Use magazines, newspapers, photo albums, home-made books, posters, bulletin boards, etc.

10. Accompany verbal language with gestures when appropriate. Comprehension is a key component of good interactive conversation.

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11. You may need to slow down your rate of speech for some children. Tape record yourself talking to the children. How do you sound?"

12. Use open ended sentences to encourage longer utterances. Example: "Tell me about your building."

13. Reinforce all attempts to communicate on the part of the child.

14. Reduce stress in the child care setting. See the module on Social/Emotional/Behavioral Needs for information on this.

15. Use positive guidance techniques that encourage cooperation, acceptance, helping, negotiating, and solving problems.

16. If needed, act as an interpreter for the child and help give him words for things we think he is thinking or feeling.

17. Give opportunities for the children to use reading and writing in useful ways. Have the children write or dictate letters requesting field trips or inviting visitors to the setting. They can make up menus for restaurant play. They can make signs for the block areas. Be creative!!

18. Encourage the use of puppets and other dramatic play materials.

19. Use food activities to stimulate language. Think of all the new vocabulary a child could learn from making quiche!

SUGGESTIONS FOR TRAINING

General Topics

- identifying children with speech and language problems
- language experiences

- techniques for developing language in children
- an evening with a speech therapist

Additional Topics of Interest to Caregivers Serving Children with Speech and Language Needs

- information on a specific impairment (e.g. cleft palate)
- using total communication
- working with a speech pathologist
- integrating children with speech and language problems
- articulation
- stuttering

Suggestions for Speakers or Consultants

- speech and language pathologist
- audiologist
- special education teacher

RESOURCES

American Speech-Language-Hearing Association (ASHA)

10801 Rockville Pike

Rockville, MD 20852

301/897-5700 or 800/638-6868

Non-Oral Communication Center

Plavan School

9675 Warner Avenue

Fountain Valley, CA 92708

714/964-2014

Trace Resource and Development Center

314 Waisman Center

1500 Highland Avenue

Madison, WI 53706

608/262-6966

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Communication Outlook
Artificial Language Laboratory
Computer Science Department
Michigan State University
East Lansing, MI 48824

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Mayer, C., *Language Disabilities*, Alaska Special Services Resource Access Project, Department of Health, Education, and Welfare, Anchorage, Alaska, 1978.

Mayer, C. *Speech and Language Development*, Alaska Special Resource Access Project, Department of Health, Education, and Welfare, Anchorage, Alaska, 1978.

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SAMPLE RESOURCE SHEET

Age of Child: 0-3

Special Need: Tamika is a one year old girl with Down Syndrome. She vocalizes frequently making sounds like "ba ba ba" and "da da da". She responds to different tones of voice and recognizes objects by their sound (e.g. microwave, telephone, and the family dog). Her hearing is thought to be normal.

I.F.S.P. Goal: Tamika will expand her expressive language.

Objective: Tamika will imitate speech sounds such as "mama" or "dada" nonspecifically during vocal play with caregivers.

Suggestions/Adaptations:

1. Repeat back to Tamika the sounds she makes. If she says "bababa", you say "bababa". Do this a few times, then change what you say to "babada" and see if she will pick up on the difference.
2. Respond to the child's sounds of "mama" and "dada" by referring specifically to mother and father. For example, "Mama's at work" or "Dada's bye bye".
3. Use "mama" and "dada" when playing peek-a-boo.

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SAMPLE RESOURCE SHEET

Age of Child: 3-5

Special Need: Neil is a four year old boy who talks quite a bit but has unintelligible speech.

He cannot pronounce the sounds made by the letters /k/, /g/, /s/, /th/, and /z/. He rarely pronounce final consonants in words. He is showing signs that he is frustrated when others do not understand him.

I.E.P. Goal: 50% of Neil's speech will be intelligible to his peers.

Objective: Neil will consistently pronounce the endings on words with final consonants that are within his repetoire.

Suggestions/Adaptations:

1. Use echo correction technique, emphasizing final consonants. For example, when Neil says "ma ha" for "my hat", you respond with "yes, that's yourrrr hattt.
2. Be careful not to overdo, because you don't want to model unnatural speech.
3. Play a fishing game. Put pictures of objects on the fish and have Neil say the name of the object he "catches". Good words to practice final consonants are" cat, hat, spoon, telephone, slide, sheep, hand, boat, farm, cup, and balloon.

SAMPLE RESOURCE SHEET

Age of Child: school-age

Special Need: Pat is an eight year old boy who stutters in pressure situations, such as reading or answering questions in front of the class, or talking on the phone to freinds.

I.E.P. Goal: To increase fluency.

Objective: Pat will be able to answer a question from a peer or teacher without getting "stuck" on the first word.

Suggestions/Adaptations:

1. Don't finish Pat's sentences for him.
2. Don't call attention to Pat's stuttering.
3. Talk in a calmer, slower, more relaxed way yourself.
4. Comment on what Pat says, not the way he says it.
5. Give Pat ample time to answer questions.

Handouts and Supplementary Materials



SPEECH AND LANGUAGE DEVELOPMENT

RECEPTIVE LANGUAGE- listening abilities and understanding of what has been said

EXPRESSIVE LANGUAGE- ability to express needs and wants via gestures and /or speech;
includes grammatical skills

ARTICULATION- production of different sounds

<u>AGE LEVEL</u>	<u>RECEPTIVE LANGUAGE SKILLS</u>	<u>EXPRESSIVE LANGUAGE SKILLS</u>	<u>ARTICULATION SKILLS</u>
birth to one month	gross awareness of sounds	cries(discomfort, vegetative) vowel-like sounds, but nasal	
two to three months	starts to turn toward loud sounds	laughing throaty sounds cooing/gooning vocalizes when others in baby's environment are talking	
four to six months	turns toward familiar voice recognizes name reacts to different intonations quieted by voice or singing	squeals, yells, growls raspberries holds out vowel sounds repeats same vowel changes loudness, pitch, rate vocalizes to self when alone & to gain attention early babbling (e.g. baba, dada)	
seven to ten months	starts to recognize familiar words follows simple commands esp. when accompanied by gestures turns head to new voices and more subtle sounds understands "no"	shouts/whispers imitates cough & tongue click babbles several syllables (sounds like first words) verbal turn-taking games vocalizes to toys	

AGE LEVEL	RECEPTIVE LANGUAGE SKILLS	EXPRESSIVE LANGUAGE SKILLS	ARTICULATION SKILLS
ten to twelve months	Understanding more names of common objects and people gives objects in response to "Give me" looks when asked "Where is _____?"	Using gestures & sounds to manipulate others first words spontaneous imitation of sounds & words plays pat-a-cake and other nursery games	
twelve to eighteen months	gives familiar objects on command recognizes names of toys, familiar people, verbs, clothes	jargon (sounds like foreign language) naming familiar objects, verbs and people vocabulary of about 10 words repeats back part of what others say (echoing)	
eighteen to twenty four months	following commands involving object manipulation points to body parts when named starting to understand descriptive words pulls person to show things or indicate wants	putting two or three words together (me go; more cookie) approximately 2 dozen words, although some may have many more "no" stage refers to self by name verbalizes toilet needs	beginning: n,p,m,t,k,g,b,h end: n,m,p vowels
two to 2.5 years	understanding function of objects points to pictures when named understands "oneness"	asking questions attempting to relate experiences answers yes/no questions using verbs, pronouns, plurals vocabulary expanding!!	beginning: d,f,y end: d,f,k,s,ng

AGE LEVEL	RECEPTIVE LANGUAGE SKILLS	EXPRESSIVE LANGUAGE SKILLS	ARTICULATION SKILLS
2.5 to 3 years	listening to and follow stories read to him (20min) recognizing locations (in, on, up, down) answers yes/no and "what" questions matches colors understands big/little points to parts of an object	using 300 to 500 words speaking in 3 to 4 word sentences knows if boy or girl gives full name using adverbs, adjectives, negation, contractions, be verbs (I'm, he's) names some body parts	beginning: w,s end: t,r,b,l,g
3 to 4 years	recognizing 1 to 3 colors following commands involving selection of 2 objects and 2 actions recognizing spatial prepositions (under,over, back of) long/short, hard/soft, rough/smooth recognizes objects by category selects correct number of of objects in group (2,3) listens when reasoned with	using 1000 to 1500 words may be dysfluent-repeating words or sounds-normal describing spatial prepositions (in, on, under) sentences of 4 to 5 words subject-verb agreement using conjunctions, negatives possessive pronouns singing songs rote counts almost to 10 tells simple stories engages in conversation identifies number of objects in group (2,3) asks how, where, when, why questions	beginning: l,r,sh ch,th,t end: v,sh should be 80% intelligible

<u>AGE LEVEL</u>	<u>RECEPTIVE LANGUAGE SKILLS</u>	<u>EXPRESSIVE LANGUAGE SKILLS</u>	<u>ARTICULATION SKILLS</u>
4 to 5 years	knows left/right recognizes discrete body parts (chin, ankle, wrist, elbow, etc.) recognizes textures, weight differences recognizes color and shapes selects "4" objects follows 2 action and 3 object commands understands conditional statements (if, because) understand time words (before, after) recognizes difference between verb tenses (past vs. future)	using 1000 to 2000 words sentences of 5 to 8 words can tell opposites fantasizing, exaggerating may discover profanity describes remote events describes how we use eyes, ears describes function of common objects asking many questions to learn about his environment] naming coins using nonsense words and rhymes naming some colors	using: z,th,j should be 95% intelligible
5 to 6 years	comprehends today/tomorrow, morning/afternoon follows 3 part commands repeats series of 4 digits and 10 words selects object when discrete part described asks what words mean understand simple addition problems when given short number problem understands 13,000 words	using 2000 or more words rote counts to 30 counts 10 objects using irregular plurals and past tense verbs using comparatives (bigger) gives address describes similarities and differences names some numbers and letters naming days of the week usually speaking in grammatically correct sentences	

compiled by Anne Osterling, M.A., CCC
 Speech-Language Pathologist
 Carle Clinic-Department of Speech-Language Pathology

HOW TEACHERS CAN HELP THE CHILD WHO STUTTERS

Do now show concern over the speech interruptions of the young child. Accept these non-fluencies as his way of talking and do not call his attention to them.

Treat the child who stutters as you would any other child.

If he is aware of his stuttering, let him know that you understand his problem and that you are interested in helping him.

Encourage him to talk in the classroom, making the oral recitation situation as pleasant as possible. Urge him to volunteer or ask him questions that can be answered rather easily. Avoid situations which may create tension for the stutterer (i.e., calling the roll alphabetically while he waits for his turn).

Do not react emotionally to the stutterer. In this way you help to control the attitude of the class.

Praise him for his attempts to speak -- not for his periods of fluent speech.

Avoid an atmosphere of tension in the classroom.

Help him increase his self-confidence. Encourage him to participate in school activities. Help him to succeed in non-speaking activities.

DO NOT:

- A. Hurry him.
- B. Interrupt him.
- C. Ask him to start over.
- D. Ask him to speak slowly.
- E. Say his words for him.
- F. Look away while he is talking.
- G. Give him devices for starting his speech, such as foot-tapping, finger tapping, arm-swinging, etc.

COGNITIVE NEEDS

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WHAT ARE COGNITIVE IMPAIRMENTS?

Most children with cognitive impairments learn at a slower rate than other children and, therefore, exhibit deficits in a variety of areas. These children may have difficulty using language, solving problems, and interacting with others. They may also have poor fine and gross motor skills and need additional assistance in meeting their daily needs. Children with cognitive impairments have a wide range of disability and a variety of functioning levels. For example, children with specific learning disabilities may have normal or high intelligence, but have trouble because the brain has trouble processing printed material. Some children with cognitive impairments have other disabilities, such as cerebral palsy, which further complicate the learning process. The main point to keep in mind is that I.Q.'s or specific labels such as E.M.H. (educably mentally handicapped) or L.D. (learning disabled) are more important in diagnosis than they are in day to day activities. Caregivers should be more interested in the abilities of children to perform activities, interact with other children, and participate in daily events. All children should be given the opportunity to participate in activities that occur naturally in the day care setting, and should be encouraged and assisted in their interactions with others.

Mental Retardation

It is important to note that mental retardation is a specific categorical diagnosis and that children who are cognitively impaired are not necessarily mentally retarded. For a child to be considered mentally retarded, he must exhibit subaverage intellectual functioning accompanied by impairment in "adaptive behavior". Adaptive behavior refers to the child's ability to perform behaviors that allow him to "adapt" to the environment such as social skills with other children. A low I.Q. is never by itself sufficient to make the diagnosis of mental retardation.

The term mental retardation is seldom used before a child is three or four years old. The term "developmentally delayed" is used to describe a child whose development is significantly behind other children his age in one or more areas of development. Many parents and professionals have become uncomfortable with the word "retarded" as it has been used frequently to put down or shame others.

There are a generally agreed upon set of terms for the levels of mental retardation. These are mild, moderate, and severe and profound. Mild mental retardation is sometimes referred to as educable mental retardation (E.M.H.). Children who are mildly retarded often learn much more slowly than other children their age. Some games and activities may be more difficult for them and they may need some special assistance to pick up on routines. Children who are diagnosed as being E.M.H. should be able to learn a great deal, but will most likely need more structure and practice to develop skills.

Children who are moderately retarded, which is often referred to as trainable mentally handicapped (T.M.H.), fall even further behind peers in all areas of development. They may have extreme difficulty learning to talk, interacting socially with others, and their behavior may be that of children half their age. Children who are diagnosed as T.M.H. will need to repeat activities many, many times before they are learned. A process called "task analysis", which will be discussed later, may be helpful for caregivers to know when working with a child with moderate mental retardation.

Children who are severely and profoundly retarded will most likely need assistance in meeting all of their daily needs and may have associated handicaps such as cerebral palsy or seizure disorders. A great deal of assistance is required to appropriately serve children with severe and

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profound retardation. A lower child to staff ratio and more one to one experiences are necessary. Often specific techniques will be needed to help the child to function and so extensive in-service training and preparation are required for caregivers.

Learning Disabilities

Children with learning disabilities have skills that are unevenly developed. A child may be very good in math but have difficulty learning to read. Children with learning disabilities are not usually retarded, although children who are retarded can also have learning disabilities. Young children with learning disabilities may have problems learning to use language. Older children may have difficulty learning to read and write. Some other characteristics of children with learning disabilities include inability to follow directions, distractibility, clumsiness, hyperactivity or hypoactivity, difficulty distinguishing left and right, impulsivity, social skills difficulties, and low tolerance for frustration.

Children with learning disabilities have problems "processing" information. This means that the child may be able to take in information from the environment, but he has difficulty acting on it. He may understand the direction "put on your coat", but be unable to perform the task as asked. Children with learning disabilities may have trouble with "sensory integration" which is described more fully in the Motor Needs module. This means that a child may have trouble coordinating information he takes in from his senses. Children with sensory integration and processing problems can be overwhelmed by all the sensory stimulation provided in an integrated child care setting.

HOW ARE COGNITIVE IMPAIRMENTS DIAGNOSED?

Cognitive impairments are usually diagnosed by a team of professionals that may include a psychologist, special educator, learning disabilities teacher, social worker, speech and language therapist, and an occupational and/or physical therapist. Input is also obtained from medical specialists as well as vision and hearing specialists. The team will do a series of assessments or tests such as the Wechsler Intelligence Scale for Children or the Battelle Developmental Index. Each specialist uses assessment tools to determine the level of functioning of a child in a specific area. The team members meet with parents to discuss the results of the assessments (which also includes observational information and information obtained from parents, teachers, and caregivers), to determine the child's strengths, needs, and interests, and to plan a program of intervention or remediation for the child.

RECOGNIZING AND REFERRING

Most elementary school age children in child care will already be diagnosed if they have cognitive impairments, although some subtle learning disabilities can be missed. Children can also be misdiagnosed, but this is rare now that more comprehensive evaluations are being done. In the past it was more common for children with hearing loss to be labeled as mentally retarded. Routine hearing and vision screenings are now being done to rule out these types of problems. Careful observation and regular contact with parents are the keys to recognizing potential problems in children. Children preschool age and younger are more likely to have undiagnosed cognitive impairments. Some high risk signs to look for in preschool age children include:

1. Cannot answer simple questions about a story by age 3.

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2. Does not give reasonable answers to such questions as "What do you do when you're hungry?" by age 4.
3. Does not demonstrate simple problem-solving patterns for bead stringing by age 4.
4. Does not seem to understand the meaning of the words "today", "tomorrow", and "yesterday" by age 5.
5. Does not demonstrate memory skills such as repeating short sequences of numbers or telling what's missing from a group of objects by age 5.
6. Is the child far behind other children his age in developing basic language skills?
7. Is the child extremely non-attentive to things going on around him?
8. Is he well behind other children his age in learning to sit, crawl, or walk?

Caregivers see children in many situations and interacting with other children every day. They need to be reminded to take into account the child's personal circumstances such as cultural background, non-English speaking home environment, and the child's individual temperament and learning style. Sometimes other impairments cause the child to have difficulty in learning (e.g. hearing loss, cerebral palsy). Rule these out first. Also note whether this is one of the youngest children in the group. See the "Identification" workshop for further information on red flags (signs to watch for). Keep in mind that these signs may be displayed by all children some of the time. It may helpful to have the caregiver ask herself "Is the child learning so slowly or is his adaptive behavior so poor that it keeps him from participating fully with the other children?"

If the caregiver suspects that the child is in need

of a referral, the parents should be consulted first. Parents may have noticed the same or similar problems at home. The child may have already been screened. If the child has passed a developmental screening and the caregiver is still concerned about the child, further evaluation may need to be pursued. A screening is just that. Some children who need services may be missed. A positive rapport and ongoing contact with parents is essential in facilitating this process. Specific information on talking with parents is given in the workshop on "Identification". Written permission from parents is required before a formal referral can be done. A caregiver can, however, talk to a professional to discuss whether or not a referral is indicated. In this case, a caregiver **CANNOT** use the child's name. **Appropriate referral sources for children with suspected cognitive impairments are local school districts for children three and up, and birth to two early intervention programs for children below age three.** Various agencies offer programs for children below age three. There is not one specific service provider, such as a school district, for very young children. Although the school district may provide this service in an area, it may also be provided by an Association for Retarded Citizens (A.R.C.), a university, or some other private agency. If a caregiver is functioning as her own "consultant" and she does not know who to contact, the local school district's early childhood program is a good place to call for such information.

PROFESSIONALS WHO MAY BE INVOLVED

There are a number of specialists who may be providing services to a child with cognitive impairments. The types of services a child is receiving will depend on the specific needs of the child and whether or not he has associated impairments. Some of the most common specialists include:

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special education teacher- usually a classroom teacher with training in special education. She conducts ongoing assessment of a child and is the person primarily responsible for the development of the child's Individualized Education Program (I.E.P.).

child development specialist- usually the primary "teacher" for a child below age three with special needs. May provide services in a home or center based program. Focus is on the Individual Family Service Plan (I.F.S.P.).

special education teacher for the learning disabled- special education teachers with additional training in working with children with learning disabilities. May serve children in a "resource room" where children in a school setting may go for part of the day to receive services individually or in small groups. Consults with classroom teachers to plan for children with learning disabilities.

speech-language pathologist- conducts screening, diagnosis, and treatment of children and adults with communication disorders (may also be called a speech therapist).

occupational therapist- evaluates and treats children who may have difficulty with self help, fine motor, and other adaptive skill deficits. Some occupational therapists (O.T.'s) work in schools, some work in clinics or hospitals, some work in early intervention programs, and some are independent. Most work primarily one to one with a child, but some do therapy with children in their natural settings (classrooms, day care center or home, etc.).

school psychologist- conducts diagnostic evaluations and administers standardized tests with children to assess educational needs and to determine program eligibility. Assists in the development of the Individual Education Plan and provides other psychological services if needed.

SUGGESTIONS FOR INTEGRATING CHILDREN WITH COGNITIVE NEEDS

1. Structure activities so that the child achieves success. A good way to accomplish this is through **task analysis**. Task analysis is breaking down a skill into small teachable parts. An example of this for handwashing might be:

- a) Turn on water
- b) Wet hands
- c) Pick up soap
- d) etc.

2. Include each child in all activities to the greatest extent possible. Some children will need assistance from the caregiver or non-handicapped peer.

3. Be consistent about your expectations.

4. Keep directions simple and clear. Give one direction at a time and follow through with the child.

5. Maintain a schedule that will assist the child in becoming familiar with the daily routine.

6. Give the child lots of opportunities for practice. Incorporate the teaching of various skills into other situations, such as discussing the color of hats, coats, etc. while working on dressing skills.

7. Reward the child through praise and other motivating situations for accomplishments and efforts.

8. Provide a language-rich environment (see module on Speech and Language Needs). Talk about what the child and other children are doing. Expand on what the child says.

Example: CHILD: "My coat."

ADULT: "That's right. That is your blue coat."

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9. Get the children talking by allowing them to share special things from home. Notes back and forth from home provide an opportunity for the provider to talk with a child who is language impaired about what happens in his home. This is especially important when parents are caught up in the rush of the day and do not have large amounts of time to discuss with the provider the many activities that have occurred in an evening or over the weekend.

10. Make use of songs, rhymes, and puppets to encourage children's language in a non threatening activity.

11. Encourage the development of motor skills through movement-to-music games, puzzles, and playground activities.

12. An obstacle course provides opportunities to develop the ability to follow directions, develop body awareness, and practice social skills as well as motor skills.

13. As the child performs an activity, talk about what he is doing and possibly describe the next step.

14. Use field trips as a chance to expand on language, motor, and social skills. Talk about what is happening, ask questions of the children, and make use of opportunities to practice climbing up stairs and walking on various terrains.

SUGGESTIONS FOR FURTHER TRAINING

General Topics

- play
- identifying children with special needs
- theories of cognitive development - Piaget etc.
- behavior management

Additional Information for Caregivers of Children with Cognitive Impairments

- information about a specific disability (e.g., Down Syndrome)
- total communication
- learning disabilities
- the multisensory approach to learning

Suggested Speakers or Consultants

- special education teacher
- speech therapist
- learning disabilities teacher
- reading specialist
- school psychologist or social worker
- rehabilitation specialist
- occupational therapist
- parent of a child with mental retardation

RESOURCES

American Association on Mental Deficiency
5101 Wisconsin Avenue, N.W.
Washington, D.C. 20014

Closer Look
Box 1492
Washington, D.C. 20013

Council for Exceptional Children
Information Center
1920 Association Drive
Reston, VA 22091

National Association for Retarded Citizens
2709 Avenue E. East
P.O. Box 6109
Arlington, TX 76011

Association for Children with Learning Disabilities, Inc.
4156 Library Rd.
Pittsburg, Pennsylvania 15234

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National Association of Developmental
Disabilities Council
1234 Massachusetts Ave., N.W.
Suite 203
Washington, D.C. 20005
202/347-1234

National Down Syndrome Congress
1800 Dempster St.
Park Ridge, IL 60068
1-800-232-6372

Foundation for Children with Learning
Disabilities
99 Park Ave., Second Floor
New York, NY 10016

SAMPLE RESOURCE SHEET

Age of child: 0-3

Special Need: Julie is a 2-year old child with a moderate cognitive impairment and some difficulty with fine and gross motor skills. She is somewhat behind other children her age in developing social competencies but is generally a happy and outgoing child.

IFSP Goal: Julie will play with a variety of toys that require fine and gross motor skills.

Objective: Julie will complete a single matching game or puzzle.

Suggestions/Adaptations:

1. Puzzle or matching game could have the identical picture, color, and outline drawn so that Julie can see where the piece should be placed by matching.
2. Puzzle could either be purchased with knobs or knobs could be added to assist her grasping each piece and practice fine motor skills. Special consideration should be given to the size of the knobs in conjunction with the level of her grasping ability. The occupational or physical therapist could provide input here.
3. The teacher could adapt the task by providing assistance such as naming the shape, color, or picture on each piece that Julie works with or by providing point cues for each particular piece

Section V - Special Needs Modules

SAMPLE RESOURCE SHEET

Age of child: 3-5

Special Need: Danny is a 4-year old boy with a mild cognitive impairment. He has difficulty following through with directions and tends to play by himself. Danny has good motor skills and seems to enjoy participating in activities that require movement.

IEP Goal: Danny will participate in activities that involve some movement with at least one other child.

Objective: Danny will assist at least one other child to set the table for snack.

Suggestions/Adaptations:

1. Reinforce Danny by providing him with the more movement oriented parts of the task such as walking back and forth to get needed items.
2. Pair Danny with a child who has well developed social skills that provide him with a good role model.
3. The caregiver should be available to stimulate opportunities for socialization such as suggesting turn taking between Danny and the other child. The teacher should provide praise to Danny for any attempts to interact with the other child and should stimulate interaction with questions about the activity and introducing new ideas to the children about what they are doing.

SAMPLE RESOURCE SHEET

Age of child: school-age

Special Need: Mark is a 9-year old child who has moderate cognitive impairment. Mark has difficulty completing many tasks and has limited language skills. He enjoys music and playing catch with a softball.

IEP Goal: Mark will follow two-step directions in a variety of tasks.

Objective: Mark will put away items when finished with them with a two-step direction from the caregiver.

Suggestions/Adaptations:

1. Mark may be having some difficulties understanding directions or statements of any length. This is sometimes referred to as problems with "receptive language". The speech therapist can provide valuable assistance and suggestions such as keeping directions short and clear.
2. Make sure that Mark is attending to you when giving directions. In a new situation, he may need to hear the direction and see the activity modeled by the caregiver at the same time before trying it himself.
3. Provide opportunities for Mark to be reinforced when he has successfully completed a task such as listening to music or having some one-on-one with the caregiver playing catch for a few minutes.

Handouts and Supplementary Materials



SUGGESTIONS FOR HELPING PRESCHOOLERS
WITH INTELLECTUAL DISABILITIES

1. Don't underestimate the child's abilities.

Mentally retarded children are often over protected and not expected to be "able to do much". The learning potential and self-image of any child can be destroyed when too little is expected.

2. Work on all areas of development, but concentrate particularly on self-help skills.

Teaching a child how to take care of himself is one of the most important skills he can learn. Sometimes a retarded child has coordination problems. He has difficulty balancing food on a spoon or unbuttoning his coat. Many times, retarded children are not given the chance to do these things themselves. Adults may find it more comfortable to wait on the child than to watch him struggle through a task. Most retarded children can learn self-help skills. Adults should encourage activities to help them learn to eat, dress, toilet and wash independently. The learning will be slower and messier than that of normal children, but such training is essential for developing a feeling of confidence.



3. Use a multi-sensory approach in teaching.

It is harder for mentally retarded children to learn. The more senses that are used in any learning situation, the better.

Try to use many senses when attempting to teach a concept or task. What he sees, hears, smells, tastes, and touches all will help him learn.

With a task like buttoning a coat, you can help the child use several senses with instructions like these:

"Put the button through the hole." This gives the child an auditory clue as to what the task is.

"Feel the button. It's smooth isn't it? And the coat is rough." Now the child has a tactual clue as to the different parts of the task.

"Watch what you are doing." This is a visual clue as to what the task looks like.

Guide his fingers through the motions of the task. Give him a clue through his muscles as to what the fingers are supposed to be doing. When many senses are involved in a task, the chances for success are greater.



4. Use a step-by-step learning approach.

Children with learning problems are often confused by tasks that appear simple to other children of the same age. If the task can be broken down into different steps, the child can practice one step at a time. Later he can put them all together. Suppose that the class is cutting out pictures of cars from magazines and pasting them on construction paper. "Cut out the cars and paste them on the paper." sounds like a simple task for most normal four year olds. But a retarded child may be totally confused by the instructions. For him, there are many, many steps in that simple order. Many skills are involved in cutting and pasting.

First, the child has to know how to cut. He may need help learning how to hold the scissors. He will have to learn how to snip pieces of paper before he can learn to cut around a picture.

He must know how to identify a car in a picture.

He must know how to dip the brush into the paste jar.

He must know how to put the paste on just one side of the picture.

He must learn which side is the right side to put the paste on.

He must learn that the picture must be placed somewhere on the construction paper.

It is difficult for the retarded child to learn all of these things at once. The process of breaking down a task and teaching it step-by-step is the only successful way to teach a child with a learning problem.

5. Be aware of the child's developmental level and teach at that level.

In learning any skill, not all children will have to start at the very beginning. It is a challenge to parents and teachers to know at what level a child is functioning, then to discover what the next steps should be. This is not easy. It requires intimate knowledge of the child's abilities and limitations.

6. Make the proper match when presenting learning situations.

If a task is too simple, the child may become bored and uninterested. He will not learn much. Some tasks will be too difficult. In this case, the child will usually become frustrated and give up. He will not learn much in this situation, either. The proper match is a learning situation in which the task is challenging enough to maintain interest, but can be successfully accomplished by the child.



7. Use repetition.

It takes longer for the retarded child to understand concepts and tasks. He learns best from short periods of training that are repeated over and over again. He does not learn well in activities that require great concentrations or long periods of time. Repetition should not be boring. It can be varied enough to provide interest.

Example: Pouring.

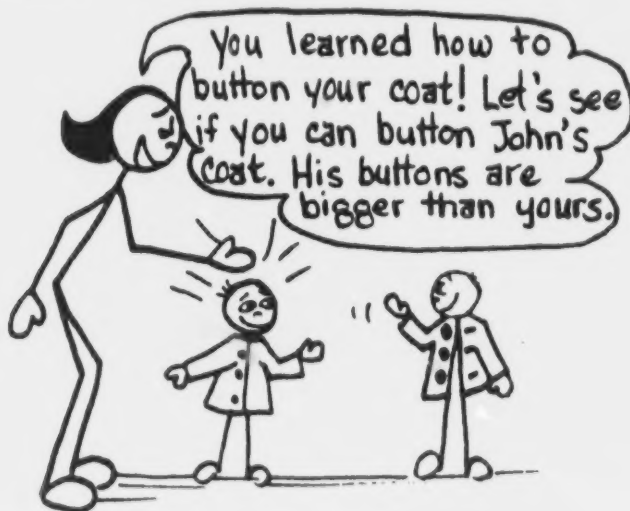


8. Avoid sudden changes in activities.

Retarded children need extra time in learning to move from one activity to another. Moving from play time to nap time, may take longer for him than for the other members of the class. Changing from one task to another is necessary and good, but the retarded child needs gradual changes. Letting him know in advance that a change is coming is one way to help him prepare for it.

9. Help the child practice new skills in different situations.

Once a task is learned, the child should try the task in a different setting, with different materials, etc. Sometimes it is difficult for the retarded child to apply what he has learned to another situation. It is important that he learns how to use what he knows, even though some parts of the task appear different to him.



10. Develop Confidence.

All children learn better when they feel that they are successful. Such feelings are most important for the retarded child. He is easily discouraged and often needs encouragement. It is important to provide activities where the child can experience SUCCESS. Repeated failure results in fear of trying new things. Success helps develop confidence and the desire to learn more. Providing experiences that give opportunities for succeeding does much to develop this necessary confidence.



The Easter Seal Society For
Alaska Crippled Children and Adults, Inc.
P.O. Box 2432, Anchorage, Alaska 99510

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CHILDREN WITH SPECIAL HEALTH CARE NEEDS

According to a 1987-88 survey by the Illinois Department of Public Health, children with chronic illness/disability are on the increase. It is estimated that 8.5% of school children have some form of chronic illness. Asthma is the most common, affecting 1/60 students. Asthma accounted for over 12,451 days lost from school in the 1987-88 school year.

Health problems in children can cover a wide variety of conditions including asthma, diabetes, anemia, heart defects, and cancer. There is a wide range of severity in health problems as there is with other types of special needs. A health problem becomes an actual health impairment when the problem seriously interferes with the child's growth and development. Some children with health impairments may be in special education and some may not. Even then, children can participate successfully in integrated child care settings.

Children with special health care needs usually miss more school or day care and spend more time at home or in hospitals than other children. They may have special medical treatments or medications that need to be administered while at school or in the child care setting. They may require special diets or adjustments in the daily schedule to allow for their endurance. Health problems can contribute to developmental delays, behavior problems, and problems with self concept.

HEALTH CARE IN THE CHILD CARE SETTING

The most important thing to do when there is a child with special health care needs in the child care setting is to **HAVE A PLAN**. The plan should include what to do on a regular basis and

what to do in an emergency. The regular day-to-day plan should include procedures for the administration of medication and instructions for the performance of any required health care treatments or procedures, such as catheterization or injections. Parents or medical professionals should make sure that caregivers know how to administer the medication or do the prescribed procedure. Specific information and suggestions for caregivers to follow should be written down. Caregivers need to observe the parents and practice procedures before performing them without supervision.

There should also be a written plan for emergencies. An emergency plan should include:

- common symptoms to watch for
- what to do when they occur
- emergency treatment procedures
- when to call parents
- who to call when parents are not available
- when to call an ambulance
- the name and phone number of the ambulance service
- the phone number of the emergency room
- the name and phone number of the physician

Some examples of written plans are included in the **HANDOUTS AND SUPPLEMENTARY INFORMATION** section of this module. Child care providers should have written permission to obtain medical treatment if parents are not available.

ADMINISTRATION OF MEDICATION

The Illinois Department of Children and Family Services outlines policies for the administration of necessary medications to a child in a child care facility (section 407.29b of the Licensing Stan-

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dards for child care centers). These include:

1. The facility shall maintain a record of the date, hours, dosages, and the name of the person administering them;
2. Prescription medications shall be labeled with the child's name, directions for administering the medication, the date and the physician's name, the prescription number, and the drug store or pharmacy;
3. The medications shall be administered as required by a physician subject to the receipt of appropriate releases from parents, and these shall be on file for each child for the administration of any and all prescribed medications;
4. Nonprescription medication may be administered upon written parental permission. Such medication shall be administered in accordance with package instructions, and, except for aspirin and aspirin substitute, shall be labeled with the child's name and dated;
5. Medications shall be kept in locked cabinets or containers which are in an area well-lighted and out of reach of children even if medications must be refrigerated;
6. The following additional procedures shall be followed for infants and toddlers:
 - a) A bulletin board or clipboard shall be placed in a visible position with the child's name, medication times, and prescription number listed on the board. Also listed shall be the name of the person administering the medication.
 - b) Each time the medication is given, the medication time shall be crossed off the board.
 - c) The same person on a shift shall be responsible for administering medication.

HOSPITALIZATION

Some children with health impairments may face frequent and/or prolonged hospitalizations. These episodes can have a very detrimental effect on the child if certain issues are not examined and dealt with in a positive manner. For example, when a child is in the hospital, he lacks opportunities to socialize and build relationships with other children. The child usually feels a loss of control over his body and feels overwhelmed by the fears of what each day and a strange provider may bring.

It is important to help these children deal with their fears and concerns as openly and concretely as possible. Puppets, books, and actual medical equipment can be used to facilitate conversation or help prepare children for a hospital stay. Older children will need assistance and encouragement in catching up on homework and keeping abreast of happenings at school and at day care. Local hospitals or agencies may provide support groups for these children and their families and could provide an excellent resource for the caregiver.

HYGIENE

Hygiene is an important consideration when serving children with special health care needs. Sanitation procedures must be strongly adhered to in order to stop the spread of communicable diseases to children who may have low resistance and may suffer more than the normal impact of an illness. Using proper handwashing technique is the most important way to prevent the spread of communicable diseases. It is also important to follow procedures for sanitizing toys, eating utensils, and diapering and toileting areas. See the HANDOUTS AND SUPPLEMENTARY INFORMATION section for more information on this topic

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IDENTIFICATION AND REFERRAL

Careful observation and close contact with parents is essential in determining the need for a referral to a health care professional. Even in children with diagnosed health problems, it is vital that the caretaker be aware of possible signs of complications or setbacks. As always, it is important to consider the child's environment and the context in which a particular behavior occurs. The caregiver should observe for unusual behavior or symptoms that occur repeatedly.

Since there are many health problems that can affect children with each having their own specific symptoms, it is not possible to list all the signs to look for when observing a child. However, if a child's behavior appears to be causing him difficulty in developing and participating fully in activities, consultation with the parents is a must. The apparent "unusual" behavior may be normal for the child's background and parenting experiences. If, on the other hand, this is not the case, the child's physician should be notified. A clear, concise report for the parents will assist them in giving necessary information to the child's physician. The parents may even request that the caregiver be available for the initial consultation or subsequent visits.

WORKING WITH HEALTH CARE PROFESSIONALS

Caregivers are often afraid to talk to health professionals about the children they care for. In some cases, however, this communication is crucial. Before a medical professional can talk to a caregiver about a specific child, the parents must give written permission. The reader is encouraged to refer to an excellent article "Talking to the Child's Physician: Thoughts for the Child Care Provider", which is included with the handouts at the end of this module, for specific

information on this topic.

Health care professionals can be excellent resources for training and information. School nurses and health educators can provide general information on various health impairments and speak to the educational consequences for the child. Hospital social workers can assist caregivers with information on positive emotional support for the child and family as well as acquaint the caregiver with possible resources in their area. One health professional that caregivers should know about is the child life specialist. A child life specialist works with hospitalized children. She provides activities and emotional support to children who are in the hospital. Some hospitals have a playroom on the pediatric ward. The child life specialist usually has a background in child development with special training in the care of hospitalized children. In some instances, a national organization for persons with a particular health condition is available. Such organizations can often provide caregivers with free or low cost materials and training.

INTEGRATING THE CHILD WITH SPECIAL HEALTH CARE NEEDS

1. Prepare for crises. Have a plan set up with the help of the child's parents and physicians as to what should be done in an emergency situation.
2. Become informed about the medications the child is taking and what the possible side effects may be. Make sure to keep track of the amount and time a medication is administered.
3. Have a plan or list of things to look for when and if a crisis occurs so that you will be able to provide the parents and physicians with as much information as possible.

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4. Write down events as soon as the child is stable, being as descriptive as possible.
5. Develop knowledge of first aid procedures and review these procedures frequently.
6. If you have questions about certain activities, list them and review them with the child's parents and physician.
7. Help the other children develop an understanding of the child's condition. Stress that the child's condition is only one part of that child. Have an activity to simulate a specific condition for the children. An example might be to weight a life vest down with heavy objects to show how a child with cystic fibrosis may feel and breathe when he is tired. Have each child try on the vest. Allow and encourage questions.
8. If the child needs special equipment, frequent rests, suffers from seizures, or requires anything that is outwardly noticeable to the other children, help them to understand what these things mean to the child and that they cannot "catch" the condition. Also let parents know that health conditions are not contagious.
9. Avoid overprotecting the child with a health impairment. It is extremely important for the child to be allowed to participate as fully as possible in all activities.
10. Make sure all necessary records such as medical consent and emergency forms are complete and up-to-date.
11. A child who has a serious health impairment may have developed some fears of hospitals or separation from parents due to frequent hospitalizations. Establishing a routine can assist the child in developing a trust of the caregiver and the environment.
12. Emotional support is crucial to these children. Provide many opportunities for them to experience success and to feel accomplishment.
13. Remember that some of these children may have had limited contact with others their age. They need opportunities to play and socialize with other children and may need extra help developing skills for sharing and cooperation.
14. Maintain frequent contact with the child's parents. The child's caregiver is a crucial link in his health care system. She can provide valuable information regarding the child's behavior, general state of health, diet, and developmental skills.
15. Make sure to alternate active and quiet activities. This enables the child who tires easily to recover and participate fully. Do not force a child with a health impairment to perform strenuous activities if he does not feel able. Most children will not limit their activity unless they really cannot take part.
16. Learn as much as you can about a child's specific health problem and how it can affect him. This will help you to answer questions from the child and other children in the group.
17. Stress can bring on crises in some types of health problems. Make the classroom as supportive and stress free as possible.

SUGGESTIONS FOR TRAINING

General Topics

- effective handwashing and sanitation procedures
- First Aid and CPR
- preventing communicable diseases
- children and allergies

Topics for Caregivers of Children with Special Health Care Needs

- information on specific health problems

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- communicating with health care professionals
- training for specific procedures
- emotional impact of health impairments

Suggestions for Speakers or Consultants

- pediatric nurse or nurse practitioner
- pediatric hospital social worker
- child life specialist
- public health nurse

RESOURCES

Local Public Health Department

AIDS Hotline
Illinois—1-800-243-2437

Allergy Foundation of America
801 Second Avenue
New York, NY 10017

American Cancer Society
219 East 42nd Street
New York, NY 10017

American Heart Association
7320 Greenville Avenue
Dallas, TX 75231

American Lung Association
1740 Broadway
New York, NY 10019

The Arthritis Foundation
1212 Avenue of the Americas
New York, NY 10036

Association for the Care of Children's Health
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016

Cystic Fibrosis Foundation
6000 Executive Blvd., Suite 510
Rockville, MD 20852

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Epilepsy Foundation of America
1828 "L" Street, N.W.
Suite 406
Washington, D.C. 20036

Illinois Department of Public Health
Office of Health Services
535 West Jefferson Street
Springfield, IL 62761

Juvenile Diabetes Foundation
23 East 26th Street
New York, NY 10010

Leukemia Society of America, Inc.
211 East 43rd Street
New York, NY 10017

Mothers of Asthmatics, Inc.
5316 Summit Dr.
Fairfax, VA 22030
703/631-0123

National Center for Education in Maternal and
Child Health
38th and R Streets, N.W.
Washington, D.C. 20057

National Center for Training Caregivers
Children's Hospital
200 Henry Clay Avenue
New Orleans, LA 70118

National Hemophilia Foundation
25 West 39th Street
New York, NY 10018

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Thompson, R. & Stanford, G. *Child Life in Hospitals: Theory and Practice*.

SAMPLE RESOURCE SHEET

Age of Child: 0-3

Special Need: Tommy is a two year old with a congenital heart defect. He has been hospitalized several times and will require at least one more surgery in the next several years. Tommy is somewhat behind other children his age in motor and play skills.

IFSP Goal: Tommy will play with a variety of toys and games that are developmentally appropriate for him.

Objective: Tommy will participate in a Simon Says or Patty Cake game with others.

Suggestions/Adaptations:

1. Tommy may need rest periods, especially after being involved in an activity that requires gross motor skills.
2. Talk with Tommy's parents and medical personnel for signs of medical distress such as when he may be receiving too little oxygen.
3. Have emergency plan and phone numbers readily available in case of a crisis.

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SAMPLE RESOURCE SHEET

Age of Child: 3-5

Special Need: Allan is a five year old boy with cystic fibrosis. He has spent a fair amount of time at home due to upper respiratory infections. Allan is expected to spend some time in the hospital in the near future for tests. His parents report that he is afraid of the hospital and they have concerns about how he will handle this.

IEP Goal: Allan will participate with other children in a tour of the local hospital.

Objective: Allan will participate in activities that deal with hospitalization such as storytime, with a "hospital" book and playing with medical equipment (stethoscope, surgical mask).

Suggestions/Adaptations:

1. Allow Allan to help with storytime by turning the pages of the book and by choosing a story from a choice of three.
2. Encourage Allan to ask questions about the story and discuss his fears.
3. Have medical equipment easily accessible for play. Let Allan fully explore each item and provide examples or explanations of how or why it is used.

SAMPLE RESOURCE SHEET

Age of Child: school-age

Special Need: Carlotta is a 10 year old girl with asthma. She requires daily medication and breathing treatments at various times and frequency. Stress and activity level can sometimes bring on an asthma attack for Carlotta.

IEP Goal: Carlotta will participate in gross motor activities.

Objective: Carlotta will play in an activity requiring gross motor skills such as softball and tumbling at least 4 times a week.

Suggestions/Adaptations:

1. Talk to Carlotta's parents and health care professionals regarding what limitations Carlotta may have. Plan her participation in activities accordingly.
2. Have Carlotta's parents and health care providers train caregivers on how to help provide breathing treatments for Carlotta (she can do most of it herself now) and any other techniques to assist her when she is having some distress.
3. Do not set Carlotta apart from the other children. It is important that she participate as fully as possible in all activities. Let Carlotta do her breathing treatment at her desk if she likes, during silent reading time.

Handouts and Supplementary Materials



PHYSICIAN'S SUMMARY OF HEALTH PROBLEMS, CONDITIONS OR DEVELOPMENTAL DISCREPANCIES WHICH MAY AFFECT THE CHILD'S EDUCATIONAL OR ACTIVITIES PROGRAM

NEED FOR ENVIRONMENTAL ADJUSTMENT OR ACTIVITIES TO BE LIMITED

PARTICIPATION IN GROSS MOTOR ACTIVITIES IS APPROVED WITH THE FOLLOWING TYPES OF ACTIVITY TO BE EXCLUDED (IF ANY):

TO BE COMPLETED BY PARENT/GUARDIAN OR CHILD CARE FACILITY:

NAME OF FACILITY OR LICENSEE _____

ADDRESS _____

NOTICE - Completion of this form is required in order for this agency to carry out its obligations under Illinois Revised Statutes, Ch. 23, Sec. 7. This form approved by Forms Management Center.

TALKING TO THE CHILD'S PHYSICIAN: Suzanne Dixon, M.D.

As more and more children are regularly cared for by child care providers, communication between that provider and the child's physician becomes more important. The provider may have important information to convey to the physician, or may wish to obtain help from the physician in caring for a particular child or in handling a health or safety issue in the center. This communication can be facilitated if the child care provider understands the physician's perspectives, biases, and constraints. As a pediatrician who has trained and collaborated on research with social scientists, and having worked with child care providers, educators, and professionals in early intervention, I know that difficulties in communication with medical personnel arise often just because we speak a different language, have varying time perspectives, and solve problems in different ways. The following guidelines are an effort to lay some of these out in order to make that communication work more easily.

Just a few thoughts:

1. Understand the physician's constraints: The physician can only discuss issues concerning a particular child if the parents or legal guardian have given permission. In other than emergencies, the physician will expect that to be a written consent form. In any case, the child care worker will have discussed permission with the family. Therefore, formalize that permission with the parents through a simple form, copy it for your records, and send the original to the physician. Do this ahead of time if possible.
2. Find out the office operating procedures. Most pediatricians have a "call hour." Find out when it is and call then for nonemergency situations. If the issue will take more than 5 to 8 minutes to discuss, set up a separate phone appointment with the physician. Ask the office staff to pull the child's chart (and permission slip) and have it on the physician's desk at the time of your call. Don't expect the physician to remember the child without a refresher (i.e., the chart). Also don't expect the physician to:
 - come out of a room to pick up your call if it's not an emergency
 - try more than twice to return your call if you are unavailable
 - discuss a child without the parent's approval

3. Format your call. Orient the physician.

- "I'm calling about (child's name). I'm (your name), his child care provider for (a week, a year)."

Say your topic sentence first with the appropriate level of urgency or worry.

- "She's fallen from the slide and appears badly hurt. I think she needs to be seen now."
- "He has gone back to wetting after full toileting training. Today he seems to be mildly uncomfortable when urinating."
- "I've been concerned about her language development for at least six months; she isn't up to her peers at all and isn't picking up."

Physicians like to hear the main point first with substantiating material afterward. In my experience, educators and child care providers like to tell the story from the beginning with descriptive detail. Physicians get distracted and lost with that approach. Hit them with the main point first, and do not add information that is not focused on this issue unless you clearly change subjects (e.g., "A second issue concerning Elizabeth is...").

4. Clearly state what you would like of the physician; don't make her guess (e.g., "I'd like you to see this child now" or "Please consider a hearing test next week during your planned visit").
5. Repeat plans or recommendations concisely to ensure that you understand each other, particularly regarding which of you will convey this information to the parents. Listing these is a style physicians can understand.
6. When discussing a case, convey observation data as separate from opinion (e.g., "David appears ill: He doesn't play actively, clings to the teacher, and is refusing foods"). These clear observations have been shown to be highly reliable indicators of illness--better in many cases than the child's temperature, although that is important too. Take it before you call about an ill child; "the child feels warm" is not good data.
7. Don't ask a physician about the health issue of a child who is not his patient. This puts him in a bind: The physician cannot ethically or legally be involved unless the child is under direct care, and yet most physicians want to be advocates for children.

8. If you are concerned about the medical care or treatment of a child, share your concerns with the parents and provide them with the names of **several** other physicians in your community for a second opinion. Beware of **single** referral suggestions as this practice alienates the local professional community, making other physicians disinclined to help and support your center.
9. If you need help with health policies, ask a local pediatrician to serve as a consultant to your center. To best use your consultant, do your homework first, using resources from NAEYC, American Academy of Pediatrics, the Red Cross, and your Local Public Health Department to develop drafts of policies or at least an outline of concerns or issues. Your consultant will bring greater enthusiasm and longevity to the project if she or he doesn't have to start from scratch on your health policies, procedures, or staff education. Always separate this role from that of health management of individual children in the center.

Child care providers and the child's physician share a common commitment to advocacy for children. A close working alliance is a natural. Speaking the same language and understanding each other's needs facilitate clear communication. Ultimately this should result in better care for children.

Suzanne D. Dixon, M.D., is Associate Professor of Pediatrics in the School of Medicine at the University of California, San Diego. She is a member of the American Academy of Pediatrics' National Committee on Early Childhood.

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GENERAL PRECAUTIONS FOR REDUCING THE SPREAD OF DISEASE

Day care center operators can reduce the risk of transmitting these diseases by:

- Maintaining a clean and sanitary environment.
- Providing ample hand washing facilities with running water and supplies, and by requiring staff and teaching children to wash their hands frequently.
- Requiring every staff member, after diapering a child, to wash the child's hands. After the child is diapered and the diapering surface is disinfected, the staff should wash his/her hands.
- Cleaning with soap and water (and mild disinfectants if appropriate) toys and other items which are likely to be handled by multiple children. Minimize the use of stuffed, furry toy animals which are difficult to clean.
- Locating diapering area away from food preparation areas and providing hand washing facilities (with running water) near diapering areas. Diapering surfaces should be disinfected after diapering each child.
- Supervising hand washing, or washing hands for children before they eat each meal or snack.
- Serving food such as popcorn in individual bowls so that one child does not touch food to be eaten by another child.
- Allowing diapered children to attend the center only when a garment covers the diaper. Preferably, clothing such as bib overalls, buttoned at the sides, or other garments which restrict the ability of the children to place their hands into their diapers, should be encouraged.
- Providing adequate separation between age groups to prevent more mobile children from having unnecessary contact with younger ones.

New day care staff should be trained, observed and retrained in proper diapering and handwashing technique. The children, the staff and even the community may suffer the consequences of improper toileting procedures.

HANDWASHING

Handwashing is the first line of defense against infectious disease. Numerous studies have shown that unwashed hands are the primary carriers of infections. When you wash and how often you wash are more important than what you wash with.

Always wash your hands upon arrival at the center, and:

- before eating or handling food;
- before feeding a child;
- after diapering and toileting;
- after handling body secretions (mucus, vomitus, etc.);
- after cleaning; and
- after giving medication.

The five most important concepts to remember about handwashing are:

- You must use running water which drains out - not a stoppered sink or container. A common container of water spreads germs!
- You must use soap, preferably liquid.
- You must use friction (rubbing your hands together). This action removes the germs.
- You must turn off the faucet with a paper towel. The faucet is considered "dirty" at all times - if you touch it with clean hands, you will be recontaminated. (Ideally, then throw the paper towel into a lined, covered trash container with a foot pedal.)
- Hand lotion should be available for staff use to prevent dry or cracked skin.

DIAPERING

Diapering Area

Follow these very important rules about the diapering area:

- Use the area only for diapering.
- Set up the diapering area as far away as possible from any food handling area.
- Provide running water so hands can be washed immediately after a diaper is changed.
- Construct a diapering surface which is flat, safe, and preferably three feet above the floor.
- Be sure this surface is clean, waterproof, and free of cracks or crevices. Cover it with a disposable cover. Use cheap materials such as paper bags, used computer paper (on the "wrong" side), rolls of paper, etc. or buy disposable squares from discount medical supply companies.
- Keep all creams, lotions and cleaning items out of the reach of children. Never give a child any of these to play with while being diapered since s(he) could be poisoned.
- Provide a belt or strap to restrain the child. Add a guard rail or recessed area as a good extra safety measure. If you have no restraint, always keep a hand on the child. Never leave the child, even for a second.

#

CYSTIC FIBROSIS: EMERGENCY PROCEDURES

WARNING SIGNS & SYMPTOMS

COMMON SYMPTOMS

1. Increase in Coughing or Mucous
2. Mucous is Greener than Usual
3. Coughing up Small Streaks of Blood with Mucous
4. Increase in Temperature
5. Fatigue
6. Breathing Faster or Harder than Usual
7. Decreased Appetite

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Allow Child to Rest
2. Encourage Fluids
3. Contact Parent
4. Aerosol and CPT Treatment if Available

IMMEDIATE DANGER

COMMON SYMPTOMS

1. Coughs up Bright Red Blood
2. Difficulty Breathing
3. High Temperature, Greater Than _____
4. Extreme Fatigue

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Allow to Rest
2. Contact Parent
3. Contact Physician

Form was individualized by: _____

Parent's Signature

Provider's Signature

Date

----- EMERGENCY INFORMATION -----

AMBULANCE SERVICE _____	Name _____	Number _____
EMERGENCY ROOM _____	Name _____	Number _____
PHYSICIAN _____	Name _____	Number _____
PARENT OR GUARDIAN _____	Name _____	Home Number _____ Work Number _____
ALTERNATE CONTACT _____	Name _____	Home Number _____ Work Number _____

I am aware that if my child has an emergency while in day care and I am not available, the director or alternate will have my child transported to the emergency room.

Signature Parent/Guardian

Date

Adapted From the Chronic Illness Program at Children's Hospital
New Orleans, Louisiana

DIABETES: (Type 1: Insulin Dependent)

EMERGENCY PROCEDURES

WARNING SIGNS & SYMPTOMS-HYPOGLYCEMIA

COMMON SYMPTOMS

1. Headache
2. Nausea/Vomiting
3. Irritability/Crying/Confusion
4. Tremors/Shaky Body Parts
5. Cold/Moist Skin

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Administer a Food or Beverage that Contains a Sugar Immediately (e.g., a half cup juice or soda). Child may need coaxing.
2. Do Not Leave Child Alone until Symptoms Disappear
3. Additional Foods May Need to be Eaten to Prevent Reoccurrence of the Reaction
4. Contact Parent
5. Contact Emergency Room if Symptoms Do Not Disappear within _____ minutes

WARNING SIGNS & SYMPTOMS-HYPERGLYCEMIA (Slow Onset)

COMMON SYMPTOMS

1. Tired/Drowsy/Weak
2. Increased Thirst
3. Increased Need to Go to the Bathroom (Increased Urination)
4. Warm/Dry Skin or Flushed Skin
5. Abdominal Pain

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Contact Parent

IMMEDIATE DANGER-KETOACIDOSIS (Medical Emergency)

COMMON SYMPTOMS

1. High Blood Sugar Level (Blood Glucose Greater Than _____)
2. Severe Nausea and Vomiting
3. Severe Abdominal Pain
4. Rapid, Shallow Breathing

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Contact Parent
 2. Contact Emergency Room
- Form was individualized by:

Parent's Signature _____

Provider's Signature _____

Date _____

EMERGENCY INFORMATION

AMBULANCE SERVICE _____

Name _____

Number _____

EMERGENCY ROOM _____

Name _____

Number _____

PHYSICIAN _____

Name _____

Number _____

PARENT OR GUARDIAN _____

Name _____

Home Number _____

Work Number _____

ALTERNATE CONTACT _____

Name _____

Home Number _____

Work Number _____

I am aware that if my child has an emergency while in day care and I am not available, the director or alternate will have my child transported to the emergency room.

Signature Parent/Guardian _____

Date _____

Adapted From the Chronic Illness Program at Children's Hospital
New Orleans, Louisiana

EPILEPSY: EMERGENCY PROCEDURES

WARNING SIGNS & SYMPTOMS

COMMON SYMPTOMS

1. An Aura (a feeling or symptom that usually happens before a seizure, e.g., funny smell, nausea, abdominal symptoms)
2. Active Seizures

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Follow Seizure Precautions
2. Keep Child Safe
3. Contact Parent

IMMEDIATE DANGER

COMMON SYMPTOMS

1. Prolonged Seizure Activity (Child specific greater than _____ minutes)
2. Falling and Hitting Head During Seizure
3. Not Able to Arouse After a Seizure
4. Trouble Breathing or Cessation of Breathing
5. Seizures Continue One After Another

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Seizure Precautions
2. Contact Emergency Room and Transport
3. Contact Parents

Form was individualized by:

Parent's Signature _____

Provider's Signature _____

Date _____

EMERGENCY INFORMATION

AMBULANCE SERVICE _____

Name _____

Number _____

EMERGENCY ROOM _____

Name _____

Number _____

PHYSICIAN _____

Name _____

Number _____

PARENT OR GUARDIAN _____

Name _____

Home Number _____

Work Number _____

ALTERNATE CONTACT _____

Name _____

Home Number _____

Work Number _____

I am aware that if my child has an emergency while in day care and I am not available, the director or alternate will have my child transported to the emergency room.

Signature Parent/Guardian _____

Date _____

Adapted From the Chronic Illness Program at Children's Hospital
New Orleans, Louisiana

HEART DISEASE: EMERGENCY PROCEDURES

WARNING SIGNS & SYMPTOMS

COMMON SYMPTOMS

1. Child Becomes Confused, Pale
2. Swelling of Hands, Feet, Abdomen, Around Eyes
3. Increased Breathing & Retractions
4. Increased Secretions
5. Increased Temperature
6. No Urination
7. Sweating

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Allow Child to Rest (lying down with head elevated)
2. Contact Parent
3. Contact Emergency Room

IMMEDIATE DANGER

COMMON SYMPTOMS

1. Blue Color Around Mouth (Cyanosis)
2. Difficulty Breathing
3. Breathing and/or Heart Stops
4. Irregular Heart Beat
5. Chest Pain

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Administer Oxygen if Available
2. Administer Medication as Needed
3. Contact Parents
4. Contact Emergency Room and Transport
5. Initiate CPR if Breathing and/or Heart Stops

Form was individualized by:

Parent's Signature _____

Provider's Signature _____

Date _____

EMERGENCY INFORMATION

AMBULANCE SERVICE _____ Name _____ Number _____

EMERGENCY ROOM _____ Name _____ Number _____

PHYSICIAN _____ Name _____ Number _____

PARENT OR GUARDIAN _____ Name _____

Home Number _____ Work Number _____

ALTERNATE CONTACT _____ Name _____

Home Number _____ Work Number _____

I am aware that if my child has an emergency while in day care and I am not available, the director or alternate will have my child transported to the emergency room.

Signature Parent/Guardian

Date _____

Adapted From the Chronic Illness Program at Children's Hospital
New Orleans, Louisiana

HEMOPHILIA: EMERGENCY PROCEDURES

WARNING SIGNS & SYMPTOMS

COMMON SYMPTOMS

1. Pain in an Area _____
2. Swelling in an Area (especially around joint) _____
3. Area Around Cut or Abrasion Continues to Expand _____

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Allow Child to Rest
2. Apply Pressure to Area that is Bleeding
3. Keep Bleeding Area Immobilized
4. Apply Cold Compresses
5. Contact Parent or Alternate

IMMEDIATE DANGER

COMMON SYMPTOMS

1. Cannot Stop Bleeding _____
2. Bleeding in Urine/Stool _____
3. Vomiting Blood _____
4. Child Becomes Weak/Pale _____

CHILD'S NORMAL SYMPTOMS

TREATMENT

1. Contact Parent
2. Contact Emergency Room and Transport

Form was individualized by: _____

Parent's Signature _____

Provider's Signature _____

Date _____

EMERGENCY INFORMATION

AMBULANCE SERVICE _____

Name _____

Number _____

EMERGENCY ROOM _____

Name _____

Number _____

PHYSICIAN _____

Name _____

Number _____

PARENT OR GUARDIAN _____

Name _____

Home Number _____

Work Number _____

ALTERNATE CONTACT _____

Name _____

Home Number _____

Work Number _____

I am aware that if my child has an emergency while in day care and I am not available, the director or alternate will have my child transported to the emergency room.

Signature Parent/Guardian _____

Date _____

Adapted From the Chronic Illness Program at Children's Hospital
New Orleans, Louisiana

SICKLE CELL ANEMIA:

EMERGENCY PROCEDURES

WARNING SIGNS & SYMPTOMS

COMMON SYMPTOMS

1. Joint Pain, Swelling and Heat
2. Irritability or Fatigue
3. Headache

TREATMENT

1. Allow to Rest
2. Contact Parent
3. Encourage the Drinking of Fluids
4. Allow to Use Bathroom

CHILD'S NORMAL SYMPTOMS

IMMEDIATE DANGER-ANEMIA

COMMON SYMPTOMS

1. Sudden Onset of Extreme Fatigue
2. Sudden Onset of Pale or Yellow Skin

TREATMENT

1. Allow to Rest
2. Contact Parent
3. Contact Emergency Room

CHILD'S NORMAL SYMPTOMS

IMMEDIATE DANGER-PAIN CRISES

COMMON SYMPTOMS

1. Severe Generalized Pain
2. Severe Headache
3. Weakness of One Side
4. Blood in Urine
5. Abnormal Behavior
6. Difficult to Arouse

TREATMENT

1. Allow Child to Rest
2. Contact Parent
3. Contact Emergency Room
4. Encourage the Drinking of Fluids

CHILD'S NORMAL SYMPTOMS

Form was individualized by:

Parent's Signature _____

Provider's Signature _____

Date _____

EMERGENCY INFORMATION

AMBULANCE SERVICE _____

Name _____

Number _____

EMERGENCY ROOM _____

Name _____

Number _____

PHYSICIAN _____

Name _____

Number _____

PARENT OR GUARDIAN _____

Name _____

Home Number _____

Work Number _____

ALTERNATE CONTACT _____

Name _____

Home Number _____

Work Number _____

I am aware that if my child has an emergency while in day care and I am not available, the director or alternate will have my child transported to the emergency room.

Signature Parent/Guardian _____

Date _____

Adapted From the Chronic Illness Program at Children's Hospital
New Orleans, Louisiana

SPINA BIFIDA: EMERGENCY PROCEDURES

WARNING SIGNS & SYMPTOMS

COMMON SYMPTOMS-Urinary Infection:

1. Decreased Urine Volume
2. Foul Smelling Urine
3. Cloudy Urine
4. Unusual Blood in Urine
5. Increase in Temperature
6. Chills

TREATMENT

1. Allow Child to Rest
2. Encourage Fluids
3. Contact the Parent

COMMON SYMPTOMS-Shunt Malfunction:

1. Changes in Vision
2. Headaches
3. Vomiting
4. Significant Change in Behavior
5. "Sleepy" or "Tired"
6. Seizure

TREATMENT

1. Allow to Rest
2. Contact Parent
3. Contact Physician
4. Implement Seizure Precautions

COMMON SYMPTOMS-Skin Problems:

1. Prolonged Redness of an Area (greater than 10 minutes)
2. Blistering
3. Abrasions/Cuts
4. Swelling

TREATMENT

1. Change Child's Position
2. Massage Reddened Area
3. Contact Parent

Form was individualized by:

CHILD'S NORMAL SYMPTOMS

CHILD'S NORMAL SYMPTOMS

CHILD'S NORMAL SYMPTOMS

Parent's Signature _____

Provider's Signature _____

Date _____

EMERGENCY INFORMATION

AMBULANCE SERVICE _____

Name _____

Number _____

EMERGENCY ROOM _____

Name _____

Number _____

PHYSICIAN _____

Name _____

Number _____

PARENT OR GUARDIAN _____

Name _____

Home Number _____

Work Number _____

ALTERNATE CONTACT _____

Name _____

Home Number _____

Work Number _____

I am aware that if my child has an emergency while in day care and I am not available, the director or alternate will have my child transported to the emergency room.

Signature Parent/Guardian _____

Date _____

Adapted From the Chronic Illness Program at Children's Hospital
New Orleans, Louisiana

SEIZURE RECOGNITION AND FIRST AID
INFORMATION FOR TEACHERS AND PROVIDERS
OF DAY CARE TO YOUNG CHILDREN

GENERALIZED TONIC-CLONIC
(Also called Grand Mal)

WHAT IT LOOKS LIKE

A convulsion, with a sudden cry, fall, bodily stiffness followed by massive jerking movements. Breathing may be shallow or stop briefly. Skin may be bluish. Possible loss of bladder or bowel control. Usually lasts a minute or two, after which normal breathing returns. Child may be confused and/or tired afterwards and fall into a deep sleep. May complain of sore muscles or bitten tongue. Seizure may be associated with epilepsy or some other health condition, like high fever or infection.

WHAT TO DO

Move child away from hard, sharp, or hot objects. Put something soft under his head. Turn child on side to keep airway clear.

DON'T put anything in his mouth.

DON'T try to hold the tongue. It can't be swallowed.

DON'T restrain movement.

DON'T try to give liquids or medicine during or just after the seizure.

Reassure when consciousness returns.

Usually not necessary to call ambulance if child is known to have epilepsy and seizure ends without difficulty after a minute or two. Call for emergency aid if child has a first seizure of unknown cause, if multiple seizures occur, if one lasts longer than five minutes, or if child seems sick, injured, or unresponsive.

ABSENCE

(Also called Petit Mal)

WHAT IT LOOKS LIKE

A blank stare, beginning and ending abruptly, lasting only a few seconds, often frequent. May be accompanied by rapid blinking, upward rolling of the eyes, chewing movements. Child may drop what he is holding. Is out of touch during seizure, but returns to full awareness once it stops. Condition may cause learning or behavior problems if not recognized and treated. Often mistaken for daydreaming or inattention.

WHAT TO DO

Observe child carefully, try to count episodes and recommend that parents tell doctor about them.

SIMPLE PARTIAL

WHAT IT LOOKS LIKE

Jerking begins in fingers, toes, or other parts of the body. Can't be stopped by child. Child stays awake and aware. Jerking may spread to involve whole body and become a convulsion (see above).

Partial sensory seizures may not be obvious to an onlooker, but child may report experiences that suggest his senses are being affected. May "see" or "hear" things that aren't there. May feel sudden fear, sadness, anger, joy. May have nausea, reports odd smells, have a "funny" feeling in his stomach, or sudden pain. May feel confused and sleepy afterwards.

WHAT TO DO

Observe child carefully, report to parents. Reassure child if he is frightened or confused. If seizure spreads to become a convulsion, handle as noted above.

Observe child's behavior and reassure. Report what has been noted to parents and suggest that the doctor be told.

COMPLEX PARTIAL

(Also called Psychomotor Temporal Lobe)

WHAT IT LOOKS LIKE

Often starts with a blank stare, followed by chewing, followed by repeated movements that seem out of place and mechanical. Child unaware of surroundings, may seem dazed and mumble. May pick at clothes, pick up and put down objects, try to take clothes off. May run, appear afraid. May struggle or fall at restraint. Once established, same pattern of actions usually occur with each seizure. Lasts only a minute or two, but child may remain frightened and confused for longer time afterwards. No memory of what happened during seizure. May be mistaken for behavior problem.

WHAT TO DO

Speak calmly and reassuringly to the child and the other children.

If the child is walking, guide him gently away from any hazards. Stay close by until seizures has ended and child is completely aware of where he is and can respond normally when spoken to.

Report to parents. If a first occurrence, recommend a medical check up.

ATONIC

(Also called Drop Attacks)

WHAT IT LOOKS LIKE

Sudden loss of muscle tone makes child collapse and fall. After a few seconds to a minute he recovers, regains consciousness and can stand and walk again. Child may have to wear head protection to prevent injury from sudden falls.

WHAT TO DO

Reassure child and check to see if he hurt himself from the fall. If a first occurrence, recommend a medical check up.

MYOCLONIC

WHAT IT LOOKS LIKE

Sudden brief muscle jerks. May be mild and affect only part of the body, or massive enough to throw the child abruptly to the floor.

WHAT TO DO

Comfort child if he hurt himself and report to parents. Child should have thorough medical evaluation.

INFANTILE SPASMS

WHAT IT LOOKS LIKE

Quick, sudden jerking movements that start between three months and three years. If a child is sitting up, the head will fall abruptly forward as if in a bow, and the arms will flex forward. If lying down, the knees will be drawn up suddenly, with arms and head flexed forward as if the baby is reaching for support.

WHAT TO DO

Look for cluster of attacks. Comfort child when they occur. Notify parents. Prompt medical evaluation is needed.

IMPORTANT: The information in this chart is not intended to substitute for physician recommendations in individual cases. In particular, guidelines on if and when to call for emergency medical assistance when a child is known to have a seizure disorder should be established in advance by the child's personal physician.

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Epilepsy Foundation of America
4351 Garden City Drive
Landover, Md. 20785

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BEST COPY AVAILABLE

Information Sheet

Child's Name: _____

Age: _____

Type of Seizure(s): _____

Typical Seizure Looks Like: _____

Does Child Have Any Warning First? _____

Typical Seizure Lasts For: _____

Frequency of Seizures: _____

Last Known Seizure: _____

How Child Acts After Seizure Ends: _____

Usual Time Before He or She Is Back to Normal? _____

Medicine Child Takes: _____

Times It Is Taken: _____

How to Give It: _____

Anything Child Not Allowed to Do? _____

If Child Has a Seizure, the Following Things Should Be Done: _____

Parent(s) Telephone Nos: _____

If Parent(s) Cannot Be Reached, Call: _____

_____ (hospital) _____ (rescue squad)

Doctor's Name: _____ Phone: _____

Other Things Babysitter Should Know: _____

Section V - Special Needs Modules

SELF HELP NEEDS

The importance of self help skills	page 64
How to help a child learn self help skills	page 64
Professionals who may be involved	page 64
Suggestions for integrating the child with self help skills difficulties	page 64
References	page 67
Sample resource sheets	page 67
Handouts and supplementary materials	

Section V - Special Needs Modules

THE IMPORTANCE OF SELF-HELP SKILLS

The development of self-help skills usually begins early in a child's life and is representative of the child's first steps toward independence. Unfortunately, many children with difficulties or delays in development may have problems performing various daily tasks of self care. Children with physical disabilities or delays in development may have problems performing various daily tasks of self care. Children with physical disabilities may lack the motor skills to independently complete dressing without special assistance. A child who is cognitively impaired may find sequencing the steps of washing his face confusing. The child who has special health needs simply may not have experienced the opportunity to develop many basic self care skills due to bouts of illness and hospitalization.

It is important for caregivers to remember what an important role self care skills play in a child's self esteem. Not only is it difficult to be unable to perform the simplest of skills, it can also be embarrassing to require assistance with many tasks that most of us would consider very personal. The child's dignity and sense of self worth should always be a high priority for the caregiver and lessening the differences between how much help each child needs should be maximized. A good example of this is providing privacy for a child who requires diapers and needs to be changed. Many children with special needs have difficulty with bowel and bladder accidents and these are to be treated as unobtrusively as possible. A child who needs extra help with dressing, feeding, or grooming should receive this assistance from the caregiver in an effective manner, that does not call attention to the child's lack of ability.

HOW TO HELP A CHILD LEARN SELF-HELP SKILLS

The ability to learn and perform basic self-help skills cannot be underestimated. There are several techniques that can be very useful for caregivers to know in helping a child learn self-help skills. The techniques are:

- a) adapting materials,
- b) adapting the activity, and
- c) breaking down the skill into smaller steps (a technique known as task analysis).

In addition to these techniques, there are professionals who can provide a great deal of expertise in assisting these children develop necessary skills. Physical, occupational, and speech therapists can provide a wealth of information on the best ways for each child to become as self-sufficient as possible.

PROFESSIONALS WHO MAY BE INVOLVED

speech therapist- can assist the caregiver in helping the child feed himself and provide tips and techniques on the best way to feed a child.

physical/occupational therapist- provides information such as the best way to position the child during activities, how to improve a child's grasp on a spoon or zipper pull, and possible extra equipment needs or ways to adapt existing materials.

SUGGESTION FOR INTEGRATING THE CHILD WITH SELF-HELP DIFFICULTIES

It is important to remember when following these suggestions that speech, physical, and occupa-

Section V - Special Needs Modules

tional therapists can provide much help to the caregiver in following through with the activities in the most positive and productive way for the child.

1. Examine what activities, toys, praise, etc. are reinforcing to the child and might best be used to encourage the child to do his best.
2. Make sure that there is adequate preparation before starting to teach the child a skill. Have all the materials ready and easily accessible.
3. Talk with the child's parents to ensure that how the child is learning a skill at home or at school is similar to the way you are teaching it. For example, a child who is only exposed to bar soap at home may be quite confused by a liquid soap dispenser.
4. If the child has balance problems or has difficulty supporting himself, make sure he is in a stable, secure position to perform the task. The physical therapist can help here.
5. If the child is struggling on a particular task, look at when it is being taught. Try to work with the child at times that he is feeling fresh and alert.
6. Some children may be easily distracted and may need to work on some self care skills in a relatively quiet environment. Something as simple as facing the child's chair away from the most active area of the room or having the child work on handwashing five minutes before the rest of the children wash up for snack can make a difference.
7. Have children practice dressing skills on their own clothing. It is a much different task to button a shirt on a doll than to button one that you are wearing.
8. When practicing feeding skills, it is important to provide nutritious and appetizing foods that will appeal to the child. A variety of types of foods should be offered to give the child an opportunity to scoop, pierce, and finger feed. Foods that are familiar to the child are a good place to start and the speech and occupational therapists can be of great assistance.
9. Many common items can be adapted to assist a child in developing a particular skill. A spoon handle can be built up to make it easier to grasp, a key ring can be attached to a zipper toggle to assist the child who has fine motor difficulty. The sides of a washcloth can be sewn together to form a "washing mitt" for the child who has difficulty holding on to the cloth. Occupational and physical therapists are specially trained in these areas and can provide much input.
10. Mirrors can be used to assist children performing self care skills. An example of this could involve the child who is learning facewashing by being shown each area of this face to wash next.
11. For some children, simply changing the way something is done or the sequence in which it is done can be of great help. For instance, many children can pick up the "over-the-head" method of putting on a coat easier than the standard way of one arm at a time.
12. Allow for plenty of time to practice the steps of a skill. We all learn at different rates.
13. Talk about what the child is doing as they perform each step of the task. For example, "That's good, Johnny, you are brushing your bottom teeth now".
14. It is important to teach self care skills in the environments in which they naturally occur, such as the bathroom, bedroom, and coat area. This increases the chances that the child will continue to remember the skills and be able to perform

Section V - Special Needs Modules

them.

15. Breaking a task into smaller steps is a very useful tool in teaching self-help skills. This is called task analysis. By teaching each small step, the child has the opportunity to achieve success as he is working toward completing the entire task.

Example: *Task analysis for putting on socks (one example)*

1. Position sock correctly with heel side down.
2. Hold sock open at top.
3. Insert toes into sock.
4. Pull sock over heel.
5. Pull sock up.

Suggestions for Specific Self-Help Skills

The following are several examples of basic self care skills that a child could be working toward achieving.

-Putting on a coat:

1. Task analyze or break into smaller steps, the task of putting on a coat.
2. Adapt the environment by moving the child slightly to the side of the coat area so as to be out of the way of the hustle and bustle of other children.
3. Adapt materials by enlarging the button holes on the coat and adding larger buttons.
4. Change the sequence by teaching the child to use the over-the-head method of putting on his coat.

-Snack:

1. Adapt materials by using a scoop bowl, varying the cup size to assist with grasp and enlarging the handle of the spoon.
2. Break down each task, such as eating with fork or drinking from a cup, into smaller steps.

3. Use foods that the child truly enjoys and is motivated to eat.

4. Vary the level of assistance the caregiver provides such as starting the child's scooping motion but allowing him to finish bringing the spoon to his mouth.

-Handwashing:

1. Use a smaller bar of soap that is easier to grasp. Provide a soap dish with raised edges to assist the stability of the soap.

2. Have the provider point to each item that the child is to use next such as the faucet handle, soap.

3. Have the child wash his hands at naturally occurring times such as after using the bathroom. Keep the child's motivators in mind such as reminding him that after handwashing it will be snack time.

-Toileting:

1. Make sure the child wears clothes that are easy to manipulate. Avoid overalls.
2. If a bar cannot be mounted on the wall next to a toilet for a child who needs it, try scooting a chair next to the toilet so the child can hold on.
3. Make sure the child is ready before toilet training.
4. Ensure privacy for the older child who is not toilet trained.

Section V - Special Needs Modules

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SAMPLE RESOURCE SHEET

Age of Child: 0-3

Special Needs: Lisa is a two year old child with Down Syndrome. She has some difficulty with gross and fine motor skills and is working on a variety of self feeding skills. She is very social and enjoys interacting with others.

I.F.S.P. Goal: Lisa will develop self feeding skills.

Objective: Lisa will develop self feeding skills.

Suggestions and Adaptations:

1. Careful consideration should be given to Lisa's positioning. She should be sitting in a stable position where she can concentrate on controlling the cup and drinking. The occupational therapist or physical therapist can be of assistance.

2. It is important to examine what kind and what thickness of liquids work best for Lisa. She may have difficulty with very thin liquids and she may have a preference for different textures and flavors. It may be best to start with something she is familiar with and likes. The speech therapist can help with this goal.

3. Lisa should be praised for her attempts at drinking and have an opportunity to interact socially with other children during snack/meal times.

Section V - Special Needs Modules

SAMPLE RESOURCE SHEET

Age of Child: 3-5

Special Needs: Greg is a five year old with some developmental delays. He has some difficulty with following through with tasks and fine motor skills. Greg is working on improving his dressing skills.

I.E.P. Goal : Greg will put on outerwear including coat, hat, and mittens, with some assistance from the caregiver.

Objective: Greg will put on his coat, hat, and mittens with some assistance from the caregiver.

Suggestions/Adaptations:

1. Make sure that directions are clear to Greg before beginning the activity. The caregiver may want to model the activity to Greg or use other children as models. Always talk to Greg about what he is doing such as "That's good Greg, you are putting your arm through your sleeve".
2. Make the activity as fun and reinforcing as possible. Remind Greg that when he gets his coat on, he will be able to go outside, be the line leader, etc.
3. Simple adaptations make the task easier. Enlarging the zipper toggle might help Greg to grasp it. The occupational or physical therapist may have some suggestions for this activity.

SAMPLE RESOURCE SHEET

Age of Child: School-age

Special Needs: Shakira is an eight year old girl with cerebral palsy. She uses a wheelchair and her ability to do things independently is of great importance to her. Shakira still requires assistance with some self-help skills and has difficulty transferring herself to the toilet if the bathroom is not adequate.

I.E.P. Goal: Shakira will perform all of the activities in a toileting sequence including transferring on and off the toilet if the bathroom is not adequate.

Objective: Shakira will transfer on and off the toilet and ask for assistance when needed.

Suggestions/Adaptations:

1. It is important that Shakira be given adequate time to attempt the skill by herself. If she needs assistance, it should be given in the most respectful and unobtrusive manner as possible. The occupational or physical therapist can provide a great deal of information of the proper way to do transfers.
2. Care should be given to ensuring the comfort and safety of both Shakira and her caregiver. Adequate training on transfers and working with persons with physical disabilities is a must.
3. Shakira's desire for independence should be fostered and she should be given ample opportunity to feel success in many activities. It may help the caregiver to attempt certain activities in a wheelchair to give her a better understanding of the difficulties involved.

Handouts and Supplementary Materials



SELF-CARE CHECKLISTEATING

Yes or No

Birth.	Swallows liquids	_____
1 mo.	Open/closes mouth in response to food stimulus	_____
1 mo.	Roots/searches for nipple	_____
2 mo.	Recognizes bottle	_____
2-4 mos.	Brings hands to mouth	_____
3 mo.	Anticipates feeding	_____
3-6 mos.	Swallows strained/pureed food	_____
4-8½ mos.	Uses tongue to move food in mouth	_____
5-8 mos.	Mouths and gums solid foods	_____
5 mo.	Feeds self crackers	_____
5 mo.	Picks up spoon purposefully	_____
5½-9 mos.	Holds own bottle	_____
6-8 mos.	Bites food voluntarily	_____
6-12 mos.	Drinks from cup held for him	_____
8-13½ mos.	Chews food with munch pattern	_____
9-12 mos.	Finger feeds	_____
11 mo.	Demonstrates food preference	_____
12 mo.	Mouthing of objects ceases	_____
12-15 mos.	Brings spoon to mouth - turns spoon over	_____
12-18 mos.	Holds/drinks from cup with some spilling	_____
12-15½ mos.	Holds cup handle	_____
12 mo.	Drooling under control	_____
17 mo.	Feeds self partially	_____
18 mo.	Chews	_____
18-19 mos.	Gives empty dish to adult	_____
18-24 mos.	Chews completely with rotary jaw movement	_____
18-24 mos.	Gives up bottle	_____
19-23 mos.	Plays with food	_____
23-25 mos.	Definite food preferences	_____
23-25 mos.	Unwraps food	_____
24-30 mos.	Holds spoon in fingers - palm up	_____
24 mo.	Suck and use straw	_____
24 mo.	Independent glass drinking - partially full	_____
30-36 mos.	Uses napkin	_____
31 mo.	Serves self at table with little spilling	_____
31 mo.	Shows interest in setting table	_____
36 mo.	Uses spoon well	_____
36 mo.	Uses fork well	_____
6 yr. 7 mo.	Uses knife well	_____

SELF-CARE CHECKLISTTOILET:

Yes or No

15 mo.	Sits on toilet when placed and supervised	_____
17 mo.	Sits on toilet when placed and left alone	_____
18 mo.	Bowel control	_____
19 mo.	Indicates wet pants	_____
18-24 mos.	Sits on potty chair/adaptive seat on toilet with assistance	_____
18-24 mo.	May be toilet regulated by adult	_____
21 mo.	Indicates need to use toilet	_____
24 mo.	Bladder control	_____
24 mo.	Rarely has bowel accident	_____
24-26 mos.	Pulls pants down with assistance	_____
24-36 mos.	Anticipates need to eliminate on time	_____
24-36 mos.	Uses toilet with assistance	_____
30-36 mos.	Distinguishes between urination/bowel movements	_____
33 mo.	Sits self on toilet	_____
36 mo.	Attempts to wipe, but unsuccessful	_____
42 mo.	Dry at nights if not taken up	_____
48 mo.	Arranges clothing	_____
60 mo.	Cleans self	_____
60 mo.	Flushes toilet	_____
60 mo.	Completely cares for self at toilet (include wiping)	_____

HYGIENE:

9 mo.	Puts arm in front of face to avoid washing	_____
21 mo.	Participates in washing face	_____
24 mo.	Brushes teeth with assistance	_____
24 mo.	Attempts to wash/dry hands	_____
30 mo./above	Helps with bathing self	_____
36 mo.	Turns on/off faucet	_____
57 mo.	Washes/dry hands	_____
57 mo.	Cares for teeth	_____
6 years	Cares for nose	_____
7½ years	Cares for hair	_____
8 years	Washes ears	_____
8 years	Bathing	_____
8 years	Cares for nails	_____

SELF-CARE CHECKLISTDRESSING

Yes or No

14 mo.	Extends arm/foot for dressing	_____
18 mo.	Undressing--Removes socks/mittens/gloves	_____
26-32 mos.	Undress with assistance	_____
26-28 mos.	Pulls pants up with assistance	_____
28-32 mos.	Dresses self with assistance	_____
30 mo.	Removes/pulls down garment	_____
36 mo.	Unties shoe bow	_____
36 mo.	Removes shoes	_____
48 mo.	Removes pull over garment (upper body)	_____
48 mo.	Puts on socks	_____
48 mo.	Puts on pull down garment	_____
48 mo.	Puts on shoe	_____
60 mo.	Laces shoes	_____
60 mo.	Puts on pull over garment	_____
72 mo.	Ties bow	_____

Fasteners:

30 mo.	Snaps	_____
36 mo.	Unfastens buttons: front	_____
36 mo.	Unfastens buttons: side	_____
36 mo.	Unfastens buttons: back	_____
34 mo.	Unfastens zippers: front	_____
57 mo.	Unfastens zippers: back	_____
45 mo.	Unfastens buckles: belt	_____
45 mo.	Unfastens buckles: shoes	_____
60 mo.	Unfastens ties: back sash	_____
30 mo.	Fastens buttons: large front	_____
42 mo.	Fastens buttons in a series	_____
75 mo.	Fastens buttons: back	_____
48 mo.	Unzips zipper: front, lock tab	_____
54 mo.	Unzips zipper - separating	_____
66 mo.	Unzips zipper: back	_____
48 mo.	Fastens buckle: belt	_____
48 mo.	Fastens buckle: shoe	_____
54 mo.	Fastens buckle/insert belt in loops	_____
6 years	Fastens ties in front	_____
8 years	Fastens ties in back	_____
10 years	Ties neck tie	_____
36 mo.	Fastens snaps: front	_____
6 years	Fastens snaps: back	_____

30 Months

- — Dress: Pulls up pants
- — Dress: Finds armholes correctly
- — Dress: Puts on shoes - any foot
- — Dress: Unbuttons one large button
- — Dress: Takes off shirt
- — Dress: Snaps snaps
- — Drinks from straw
- — Names mirror image
- — Answers to "What is your name?" by first name
- — Play: keeps time to music by stamping/clapping
- — Play: Plays in same activity with peers, not necessarily interacting (parallel play)

36 Months

- — Dress: dresses with supervision (pants, shoes)
- — Dress: knows front from back
- — Dress: unbuttons shirt-(front)
- — Washes and dries hands (when prompted)
- — Toilet: goes alone, dry at night
- — Understands taking turns
- — Can match colors

42 Months

- — Dress: Puts on sock unassisted
- — Dress: Zips front zipper
- — Dress: Buckles a belt
- — Buttons a series of 3 buttons
- — Washes and dries hands/face spontaneously
- — Takes toilet responsibility (and arranges clothing)
- — Pours without spilling
- — Associative play-replaces parallel play
- — Separates easily from mother
- — Contributes to conversation
- — Likes to help adults/seekes their approval

48 Months

- — Dress: Puts on shoe on correct foot
- — Dress: Removes pullover garment
- — Dress: Buttons shirt
- — Replaces towel on rack or disposes of paper towel into waste basket (after washing hands)
- — Play - cooperates with other children
- — Knows first & last name

54 Months

- — Dress: Inserts belt in loops
- — Dress: Zips a separating zipper
- — Washes face without supervision
- — Play: shows off dramatically (performs for peers)
- — Play: plays dress up
- — Chooses fork over spoon when appropriate
- — Holds fork in fingers rather than fist
- — Communication: calls attention to own performance

54 Months (cont.)

- — Communication: Relates fanciful tales
- — Communication: Bosses & criticizes
- — Communication: Expresses feelings

60 Months

- — Dress: laces shoes
- — Dress: Puts on pullover garment correctly
- — Dress: Fastens snaps on back
- — Washes hands at appropriate times, such as before meals, after toileting, when dirty.
- — Brushes teeth, prepares brush and rinses
- — Sleeps quietly through the night
- — Spreads with knife
- — Asks meaning of words

66 Months

- — Dresses & undresses with no assistance (except tying shoes)
- — Does simple errands
- — Can tell address
- — May have a preferred playmate
- — Gets along well in small groups (2-5)
- — Cooperates with companions
- — Begins competitive and team play
- — Appreciates meaning of clock time in relation to daily program

72 Months

- — Dress: Ties bows (and shoe laces)
- — Bathes self with assistance
- — Communication: recites numbers to 30
- — Communication: differentiates A.M. & P.M.
- — Communication: knows right and left consistently

(Completed by Grace Baranek, O.T.S. And Lynne Barnes, O.T.R.
Carle Foundation Hospital O.T. Dept.)

TOOTHBRUSHING FOR HANDICAPPED CHILDREN

Toothbrushing is an activity carried out by most parents and sometimes teachers. While its most commonly achieved objective is clean teeth and better dental hygiene, this activity can be one of the most helpful in organizing sensory input within the mouth. Since parents and teachers are likely to be performing toothbrushing on young children, it has been found successful in altering sensation without burdening the caretakers with another activity or exercise.

EQUIPMENT--Small toothbrush or the nuk toothbrush set

- Choose the toothbrush to fit the child's mouth size
- Gauze wrapped around the brushers finger works well if there is difficulty with excessive bleeding of the gums
- Toothpaste is optional
- In the event that toothpaste is used, a small amount is all that is necessary
- Glyoxin can be used when gum tissue cannot be touched

POSITIONING--Position the child as one would his/her regular feeding program

- Use a small basin or wheel the child up to the sink

TECHNIQUE--If the child needs oral control during eating, it is likely to be necessary during toothbrushing also

- 1) Start on the upper, less affected side. Think of each tooth as having three sides-outside, inside and cutting edge.
- 2) Brush the upper teeth and gum with small circular motions from back to midline. Stop. Let the child spit out the toothpaste or wait until the child has swallowed. Do not cross midline, but turn the toothbrush and brush the other side. If you think of the mouth in four quadrants, you have just finished the upper right and upper left on the outside.
- 3) Brush the inside of the teeth and gum in the same manner, but take care to be quick, precise. Do not cross midline. Stop after completing one quadrant and wait for a moment so the child can spit or rest. Move to the inside of the opposite quadrant.
- 4) Brush the cutting edge of the teeth the same way.
- 5) The rigid organization imbedded in this procedure not only ensures clean teeth and healthy gums, but also assists the sensory organization within the oral cavity.
- 6) Proceed to the lower teeth and gums and proceed as before.
- 7) Finish the toothbrushing by brushing the tongue one time. Start at midline and brush toward the tip of the tongue.

SOCIAL, EMOTIONAL, AND BEHAVIORAL NEEDS

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SOCIAL, EMOTIONAL, AND BEHAVIORAL PROBLEMS

Social, emotional, and behavioral problems are interrelated. This manual uses the term SOCIAL difficulties to mean problems the child has with relating to others (children and/or adults) and participating in daily activities in a developmentally appropriate manner. The term EMOTIONAL difficulty is used to refer to the child's inner experiences and feelings of self-worth. BEHAVIOR is a problem when it deviates from the cultural norms for the child's age. Some examples of social, emotional, and behavioral problems that can be diagnosed are depression, autism, attention deficit-hyperactivity disorder, childhood psychosis, conduct disorders, or childhood schizophrenia.

Social, emotional, and behavioral problems can range in intensity from mild to severe and can be manifested in different ways by different children. Caregivers need to know that a child may be diagnosed with a particular disorder but not exhibit all the characteristics of that disorder in the same degree or at all. Social, emotional, and behavioral problems can affect the child in some situations and not others.

In the Project Head Start manual **MAINSTREAMING PRESCHOOLERS: CHILDREN WITH EMOTIONAL DISTURBANCE**, the behavior of children with severe emotional disturbances is described as being withdrawn, anxious, aggressive, hyperactive, or psychotic. A handout at the end of this module describes these behaviors and possible intervention strategies. These are good functional descriptions of behavior. This manual is written from the perspective that some children experiencing emotional problems do not always fit into these categories. A child from a substance abusing family may have some very important social and emotional needs, yet appear to be a "perfect child". Children who have been abused or neglected also have special

needs which will be addressed generally in this manual.

CAUSES OF SOCIAL, EMOTIONAL, AND BEHAVIORAL PROBLEMS

Causes of social, emotional, and behavioral problems can be very difficult to determine. These kinds of problems can be caused by a number of biological factors, environmental factors, or a combination of the two. Many social, emotional, and behavioral difficulties that were once considered to be caused by child-rearing or other experiences have been found to have biological or genetic bases (e.g. autism, schizophrenia, depression). Many professionals consider attention deficit-hyperactivity disorder to be a genetic or biochemical disorder that is greatly affected by environmental factors. Some social, emotional, and behavioral difficulties may be primarily environmental. Children who are sexually abused may have no biological predisposition toward these kinds of difficulties, but develop problems as a result of their traumatizing experience(s). Children who go through infancy without developing an attachment to a primary caregiver for whatever reason are at a very high risk for the development of social, emotional, and behavioral problems.

Children with other handicapping conditions can develop social, emotional, or behavioral problems as a result of their disability or others' perceptions of it. A child with a communication impairment may withdraw from others because he is ridiculed or because interacting with peers is too difficult for him. Even mild impairment can cause significant social and emotional consequences.

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STRESS IN CHILDREN

As with adults, children also experience stress. They, however, have fewer options available to them to help them cope effectively with the strain. They have not yet developed strategies to help them cope, and may not even be aware that they are experiencing stress. Consequently, it is difficult for families and caregivers to identify when children are experiencing stress and when to provide them with assistance they need to help them deal effectively with troubling experiences that are beyond their coping abilities.

Stress that is likely to create social, emotional, or behavioral problems in children can be described as an emotional shock that creates damage to an individual's psychological development. It may be a single experience or an on-going situation. In its most traumatic form, stress is experienced as overwhelming feelings of helplessness and hopelessness, loss of control, loss of safety, and vulnerability. Stressful events can include: divorce and a long custody battle, the birth of a new sibling, harsh, restrictive, and unrealistic discipline, incest, death of a family member, illness in the family or of the child, violence in the home, witnessing family violence or an accident, deprivation and neglect, and sexual assault. Stressful events may be physical or purely psychological.

The impact of stressful events on children must be considered in terms of the environment in which they live and develop. What is traumatic for one child, may be just a bad experience for another. Additionally, the child's personality must be considered. Temperament, strengths, developmental stage, attachment and relationships, abilities and the availability of resources and support must be considered.

SELF ESTEEM

Self esteem is often lacking in children with social, emotional, and behavioral problems. Even the child who acts very selfishly or exhibits extreme bravado is probably lacking in self esteem and self confidence. Self esteem is the child's feelings of self worth. It involves feeling loveable, capable and unique. Children with social, emotional, or behavioral needs often receive a lot of negative reinforcement or no reinforcement at all. This contributes to further decline in self esteem. The most important thing we can do to help a child with social, emotional, and behavioral problems is to build up the child's self esteem. Some tips for increasing self esteem include:

1. Show the child affection through touch and physical contact. Be sensitive to the child's ability to handle touch. Some children withdraw from physical contact at first.
2. Use "encouragement" versus "praise". Encouragement gives reasons. For example, "I was really happy when you washed the table. Now I only have two more to do!"
3. Point out things about the child that make him unique. For example, "You're really good at running." or "You have a great sense of humor."
4. Avoid ridiculing or shaming.
5. Use private encouragement for children who would be embarrassed by it in public.
6. Give children responsibilities which are appropriate for their developmental age.
7. Provide alternate activities to help children get experience in making choices.
8. Teach children good manners so that they will be more likely to have positive interactions with others.

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9. Plan activities so that children achieve success. Help the children to break large tasks into small steps.

10. See the SUGGESTIONS FOR INTEGRATING at the end of this module.

IDENTIFYING CHILDREN WITH SOCIAL, EMOTIONAL, AND BEHAVIORAL NEEDS

Children who are emotionally healthy are:

1. working on age appropriate emotional tasks
2. are able to separate from their families without a great deal of stress and form an attachment relationship with at least one other adult in the day care setting
3. are able to conform to age-appropriate rules fairly easily
4. are able to become deeply involved in play
5. are developing abilities to inhibit action and concentrate
6. are not unusually withdrawn or aggressive
7. are able to express and deal with feelings in an age appropriate manner

Children with social, emotional, or behavioral needs display a consistent pattern of social and emotional adaptation. In other words, the behaviors are:

- a) displayed often
- b) persist over a long period of time
- c) too extreme

Observe the child. Does his behavior keep him from participating fully with the other children? Is it hard for him to learn new skills? Is it hard to

get along with this child? Children with special needs in this area may have frequent illnesses with no organic causes. Children may also have trouble with headaches, bedwetting, overeating, or nailbiting. They may have delays in speech and language development. They may stutter. Some children are very aggressive and some are very withdrawn or pre-occupied. They may be isolated, secretive, or non-communicative. Some may have poor eye contact. Some children may be extremely belligerent, lie or distort the truth, or blame others for things they did not do.

Before making a referral to a mental health professional, a caregiver should try to discover the cause(s) of a child's problem. She should also try some different approaches for meeting the child's needs or changing his behavior. It is very difficult to identify social, emotional, or behavioral needs in a screening situation. A child with problems may not appear to be delayed. When making a referral, the caregiver should be sure to give specific, concrete examples of the behavior that concerns her. This will help the special service personnel to identify areas of need.

Children with special needs in the social, emotional, or behavioral areas can be referred to mental health professionals in the public school, to community mental health agencies, to pediatricians, or to private service providers such as social workers or family counselors. There is no one specific referral source for children with social, emotional, or behavioral needs, however it is usually best to start with the school or the child's physician.

CHILDREN WHO HAVE BEEN ABUSED AND/OR NEGLECTED

Children who have been abused or neglected are at high risk for a variety of problems both physical and social, emotional, or behavioral. Chil-

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dren who have been abused or neglected often show delays in one or more developmental areas. Children with disabilities are also abused or neglected more often than non-disabled children.

Children can be abused or neglected in a number of ways. Behaviors that constitute abuse and neglect are difficult to define. As a result, there are not universal definitions of what constitutes abuse and neglect.

Physical abuse involves any behavior that results in injury to a child. Children can be physically abused without displaying such visual signs as bruising, swelling, and cuts. Harsh corporal punishment that involves frequent hitting or smacking of the child is by definition physical abuse. Children who are abused feel bad about themselves. They have low self esteem. Physically abused children are often avoidant, withdrawn, or depressed. These children suffer from severe relationship difficulties. They cannot trust their parents and, in fact, they may have relationship difficulties with all the adults in their environment. Interaction with adults is a painful experience. Coupled with this, is the fact that the experience of physical abuse may be feigned as discipline, for the child's good, and it may be sporadic. Behaviors that are ignored at one time may be responded to with physical abuse at another.

Sexual abuse is ANY sexual activity between an adult, or older person and a child. Sexual abuse does not necessarily involve an assault that results in physical injury or apparent emotional distress. Stroking a child's genitals or forcing a child to touch an adult's genitals is sexual abuse. The key element in sexual abuse is that an older, more powerful, more responsible member of society is participating in an activity with a child that is not age appropriate for that child. Children cannot willingly participate in sexual activities with adults. Children are never responsible for

the occurrence of sexual abuse. There is always an element of power and control in a relationship where sexual abuse is occurring and sexual activity with children is sexual exploitation. Sexual abuse elicits powerful emotions. Adults in the environment and abused children alike may have difficulty accepting and recognizing feelings associated with sexual abuse. These feelings include a sense of guilt that they somehow provoked the assault, feelings of being soiled and imperfect, a sense of shame and unworthiness, and feelings of powerlessness. They feel significantly different from other children. These feelings are compounded by the fact that often the abuser is a family member such as a father or step-father, and the child has love mixed with negative feelings. The abuse may occur in the context of what appears to be a good relationship. Additionally, the sexual behavior may have been a pleasurable experience that the child enjoyed. One final note about sexual abuse. There is growing evidence that male children are sexually abused and exploited at about the same rate as females.

Physical and sexual abuse is often accompanied by emotional abuse, however, it also occurs alone. It is difficult to define and to identify. The difference between poor parenting and emotional abuse is not clear. Parental attitudes and activities that interfere with the development of a child are emotional abuse.

REPORTING CHILD ABUSE AND NEGLECT

All licensed child care providers are "mandated reporters". This means that they are required by law to report any suspected cases of child abuse and neglect to the authorities. A detailed handout on identifying child abuse is included at the end of this module for your information. All caregivers should be informed about what to look for

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when suspecting child abuse. The Department of Children and Family Services will do training sessions for child care providers on this topic also. Every provider should attend one of these sessions. All suspected cases of child abuse should be reported to the National Child Abuse Hotline. The phone number is:

1-800-28 ABUSE

When making a report, the operator taking your call will obtain as much information from you as she can. A follow-up visit by a local child abuse investigator will be done within 24 hours. A determination will be made at that time as to whether or not the report is "indicated", which means that the abuse did in fact occur. What happens next will depend on a number of factors. The child will not be removed from the home unless he is considered to be in danger of further abuse. Every effort will be made to maintain the family.

WORKING WITH THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES

When children are involved with protective services, day care is often offered or required of the family. Unfortunately, these are usually children with a variety of social, emotional, or behavioral needs. Many day care providers feel totally unprepared to meet the needs of these children. They may feel overwhelmed by inappropriate or different behavior that is not understood. The Department of Children and Family Services has strict guidelines for confidentiality. Unless the child is considered to be a ward of the Department, information about the child's background cannot be disclosed without parental permission. Even if the child is a ward, only information that would help the provider to serve the child better would be disclosed. It is recommended that some basic information about the home life of the

child and the type of mistreatment he has suffered be obtained if at all possible. Written permission (called RELEASE OF INFORMATION) from the parents or authorized agent (for a ward) is required to share information between the Department and a child care provider. Sample forms that can be used for this are included in the PROCEDURES section of the manual. If a child is involved with protective services, he has probably been abused or is at very high risk for being abused. It is important that providers observe these children closely for signs of mistreatment. The reader is referred to the HANDOUTS section of this module for information on recognizing signs of child abuse and neglect. Suspected abuse should be **promptly** reported to the Hotline or to the child's caseworker, if you know who she is and she is readily available. Observations should be carefully documented.

WORKING WITH CHILDREN WHO HAVE BEEN ABUSED OR NEGLECTED

A child's behavior may be a clue to what kind of home life he has had. Keep in mind that children who have been abused usually come from very inconsistent backgrounds. They may be loved one minute and beaten the next. What is acceptable one day is not acceptable the next. Children who exhibit violent behavior often come from violent homes (although violent behavior may also be biologically based). The child's own violent behavior may be one way that he feels power or control. He has learned that acting violently is one way to feel or be powerful. Children who have been severely abused are often withdrawn and fearful. Children who have been sexually abused may exhibit role reversal or act out sexually. Some children who have been abused exhibit clingy or babyish behavior. Children who have been neglected are often dirty, hungry, and wear clothes and shoes that are too small or large. Their behavior may be very

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mature or very immature.

The South Carolina Educational Television Network has produced a series of five videotapes called *Caring for Pretty Special Children* about working with children in day care who are involved with protective services. Some of the guidelines for working with "Pretty Special" children include:

adjust expectations- take the child where he is and help him to achieve the next step. Try not to get frustrated with slow progress.

avoid forced participation- a child may not be emotionally or physically ready to participate in some kinds of activities. Some children are not used to control even if they have been abused.

encourage interaction- organize the child care environment so that children have the maximum opportunity to socialize and be with other children. Sometimes it is helpful to pair a very social child with a withdrawn child for some activities.

provide appropriate experiences- orchestrate success for the child. Make sure activities available are developmentally appropriate for the child. Field trips and other enrichment activities are important.

encourage role play- the child can play out themes in his own life through role play. Provide materials such as puppets, playhouses, little people etc. to encourage this kind of play.

provide a quiet place- all children need to get away from the group once in awhile. Respect the child's right to privacy while he is in the quiet place.

MEDICATION

Some children with social, emotional, or behavioral needs may take medication in order to improve their day to day functioning, to help them learn better, or to reduce symptoms that may be distressing to themselves or others. Medication can help the child to feel competent and in control of himself. Medication should not be used as a sole source of intervention with a child. Counseling, therapy, behavioral, and/or cognitive interventions are indicated for the child with social, emotional, or behavioral needs who are on medication.

It is important for caregivers to monitor the effects of medication. The purpose of monitoring is to help the physician to decide whether or not a drug is working effectively and whether adjustments need to be made. The effects of medication will change as the child grows and changes physically. Some things to monitor include the child's behavior, how and when the drug takes effect and when it wears off, possible side effects, appetite, tics, etc. Physicians do not see children often enough to judge the effects of medications without input from those involved with the child on a daily basis. Consultants and caregivers should refer to the HEALTH NEEDS module for more information on medications.

PROFESSIONALS WHO MAY BE INVOLVED

Many different types of professionals may be involved with children with special social, emotional, and behavioral needs depending on what types of needs the child or family has. Some examples are:

psychologist- assesses, diagnoses, and treats children with social, emotional, or behavioral problems.

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social worker- assesses adaptive functioning. Provides counseling or therapy for children or families individually or in groups. May provide consultation to the classroom teacher regarding behavior management and other issues. May work in a school, mental health agency, or privately.

behavior disorders teacher- a special education teacher with special training in working with children with behavior disorders. May work directly with children in a self contained classroom or resource room or provide consultation to teachers serving children with behavior disorders in the regular classroom.

department of children and family services staff- investigates reported incidences of child abuse and neglect, works closely with the court system, follows up with families, refers children and families to other agencies or individuals for services, etc.

children's home and aid society staff (or other similar agency staff)- agency contracted by D.C.F.S. to recruit and monitor foster homes and day care homes for children in foster care. Provides family and child interventions such as counseling or play therapy, for those who need it.

psychiatrist/physician- assesses, diagnoses, and prescribes medication for children with social, emotional, or behavioral needs. Physicians may rule out other types of physical problems. Psychiatrists usually see only the most extreme cases.

INTEGRATING THE CHILD WITH SOCIAL, EMOTIONAL, OR BEHAVIORAL NEEDS

1. The first step in working with children with social, emotional, and behavioral needs is to establish **trust**. Trust is established by providing consistency; consistent meeting of the child's

physical needs, consistent behavioral expectations, consistent routines, and by consistently showing a child that you **care about him** no matter what he does, thinks, or feels.

2. Fine tune your skills of behavior management. See the BEHAVIOR MANAGEMENT WORKSHOP for some ideas.

3. Help children to see the difference between accidental aggression and hostile aggression.

4. Set clear limits against aggression. Caregivers need to know that hurting others is NOT acceptable.

5. All caregivers should work together so that children can have consistent behavior management.

6. Provide adequate space and materials for the children. Environments that are too crowded or inadequately equipped lead to increased social and behavioral problems.

7. Teach children that feelings are okay, but certain behaviors are not.

8. Gross motor activities release excess energy and can biochemically decrease feelings of depression and aggression. When you or the children are having a bad day, spend more time outdoors or use an activity record with lots of physical activities.

9. Provide a wealth of stress reducing activities. Besides gross motor activities, most creative or open-ended activities can help to relieve stress. Examples are water play, play dough, woodworking or other construction activities, easel painting, and music. Keep in mind that these activities should be available on a daily basis and should not involve much teacher direction.

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10. Another technique that you can try on a bad day is an adaptation of the "primal scream". Go outside and have the children yell the funniest word they can think of over and over at the top of their lungs! Be careful about using this technique if you don't have sympathetic neighbors.
11. Encourage the children to take care of each other. Ask one child to help another do something. Encourage children to show projects to others. Show the others how to ask questions about the project. Have the children tell each other what they like about other people.
12. Use direct teaching procedures for teaching social skills. In small groups, go over ways to "make a friend" or "how to ask for a toy". Let the children practice skills by role playing. Puppets can also be used. Try demonstrating the wrong way to do something. Kids love to point out mistakes that adults make.
13. Involve children in projects that take longer than one day. This helps a child to learn planning and organizational skills. Group projects teach cooperation and teamwork.
14. Work with families to identify what might be upsetting a child.
15. Help children work through feelings by encouraging dramatic play.
16. Avoid using games and activities that have a "winner".
17. Recognize that, for some children, progress will be slow.
18. Treat children with chronic disturbance or mental illness as much like the other children as possible.
19. Use the advice of experts.
20. Caregivers working with disturbed children need extra support. This could be emotional or physical (volunteers) support.
21. Organize the environment. Organized environments help children to be more focused and help them to control their own behavior.
22. Be a good listener. Reflect the child's words and feelings. Don't give unwanted or unnecessary advice.
23. Provide a healthy diet for the children. Avoid too many refined foods or an excess of sugar sweetened products.
24. Demonstrate self esteem and coping skills yourself.
25. Help children distinguish fantasy from reality.
26. Find individual talk time. If this seems unrealistic, think in terms of one minute segments of time.
27. Use books to demonstrate coping or problem solving strategies, or to encourage discussions. This is called bibliotherapy.

SUGGESTIONS FOR TRAINING

General Topics

- Behavior management
- Working with parents
- Children's mental health
- The development of attachment
- Recognizing abuse and neglect
- Self esteem
- Helping children manage stress
- Biological and biochemical causes of social, emotional, and behavioral problems.

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Topics of Interest to Caregivers Serving Children with Social, Emotional, or Behavioral Needs

- Working with mental health professionals
- Therapeutic uses of play
- Information on specific social/emotional/behavioral needs
- Children in foster care
- Working with children who have been abused

Possible Consultants

- Child psychiatrist
- Psychologist
- Social worker
- Play therapist
- Mental health professional
- Behavior disorders teacher (B.D. teacher)
- Teacher of the emotionally disturbed (E.D. teacher)
- Behavior management specialist
- DCFS investigator (recognition of abuse and neglect)
- Developmental pediatrician

RESOURCES

1-2-3 Discipline
Child Management Center (Dr. Phelan)
507 Thornhill
Carol Stream, IL 60188

American Academy of Child Psychiatry
1800 R Street, N.W., Suite 904
Washington, D.C. 20009

American Association of Psychiatric Services for Children
1701 18th Street, N.W.
Washington, DC 20009

American Foster Care Resources
P.O. Box 271
King George, VA 22485

American Psychological Association/Division of Child and Youth Services
1200 17th Street, N.W.
Washington, DC 20005
Child Welfare League of America, Inc.
67 Irving Place
New York, NY 10003

Center for Attitudinal Healing
19 Main Street
Tiburon, CA 94920

Children Are People, Inc.
493 Selby Avenue
St. Paul, MN 55102

Children of Alcoholics Foundation, Inc.
200 Park Avenue, 31st floor
New York, NY 10166
212/949-1404

COA(Children of Alcoholics) Review
The Newsletter About Children of Alcoholics
P.O. Box 190
Rutherford, NJ 07070
201/460-7912

Council for Children with Behavior Disorders
1920 Association Dr.
Reston, VA 22091

Council for Exceptional Children
Division for Children with Behavioral Disorders
1920 Association Drive
Reston, VA 22091

Families as Allies Project Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their Families
Regional Research Institute for Human Services
Portland State University
Portland, OR 97207-0751
503/464-4040

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Foundation for Child Mental Welfare
255 W. 71st Street
New York, NY 10023

International Society for Autistic Children
1A Golders Green Road
London, NW11 8EA
England

The National Association for Children of
Alcoholics
13706 Coast Highway, Suite 201
South Laguna, CA 92677
714/499-3889

The National Association for Mental Health, Inc.
1800 North Kent Street
Arlington, VA 22209

The National Consortium for Child Mental Health
Services
1424 16th Street, N.W., Suite 201A
Washington, DC 20036

National Society for Autistic Children
621 Central Avenue
Albany, NY 12206

Parents Anonymous
National Office
7120 Franklin Avenue
Los Angeles, CA 90046
1-800-371-3501

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SAMPLE RESOURCE SHEET

Age of Child: 0-3

Special Needs: Marty is a nine month old child who is diagnosed with non-organic failure to thrive. He is in a foster home because his teenage mother neglected him and he goes to a day care home during the day.

IFSP Goal: Marty will gain weight.

Objective: Marty will take 6-8 ounces of formula in one feeding.

Suggestions/Adaptations:

1. Respond promptly to Marty's cues that he is hungry. Feed Marty every time he acts hungry.
2. Make feeding time a relaxed time. Hold Marty and use lots of face to face eye contact. Talk softly or play soft music while he is eating.
3. Do not force feed. Forcing Marty to eat will make mealtime a negative experience.
4. Have the same person feed Marty each time if possible.
5. Make sure Marty is in a comfortable upright or semi-reclining position while he takes his bottle.
6. Record when and how much Marty eats each day.

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SAMPLE RESOURCE SHEET

Age of Child: 3-5

Special Needs: Lucy is a four year old who is extremely aggressive. She bites and scratches the other children when she does not get what she wants. This happens more than three or four times a day. Two parents have removed their children from the day care center she attends because of her behavior.

I.E.P. Goal: Lucy will share toys willingly.

Objective: Lucy will ask before she takes a toy from another child two times a day.

Suggestions/Adaptations:

1. Teach Lucy what to say to another child when she wants a toy that another child has. Have her practice this with another child or a puppet.
2. Reinforce Lucy every time she asks before taking a toy. A reinforcement should be something Lucy likes and should be given promptly.
3. If possible, have duplicates of favorite toys.
4. Model asking another child for a toy.
5. Observe Lucy to find out if she is aggressive toward just one child or to a lot of children. Also try to find out if Lucy is aggressive at certain times of the day more than others.
6. If Lucy takes a toy away from another child without asking, tell her that she needs to ask before taking a toy. Give her the words and have her then ask the other child if she can have the toy.

SAMPLE RESOURCE SHEET

Age of Child: School-age

Special Needs: Jerome is a nine year old boy who is diagnosed with attention deficit-hyperactivity disorder. He has normal intelligence, but is very impulsive and overactive.

I.E.P. Goal: Jerome will increase his attention span.

Objective: Jerome will be able to play a simple board game from beginning to end.

Suggestions/Adaptations:

1. Choose a game that Jerome really likes (try Uno).
2. Keep him actively involved by saying things like "You're really doing well" or "Guess what number P.J. will lay down next", etc.
3. Set a time limit for the game. Use a timer. Gradually increase the amount of time.
4. Shorten the game at first by using less cards.
5. Give Jerome a job such as keeping track of how many times a Reverse card is played.
6. Use encouragement. Say things like "I really like playing games with you when you finish them". Teach the other children how to use this technique.

Handouts and Supplementary Materials



CHECKLIST OF PHYSICAL AND BEHAVIORAL INDICATORS OF
CHILD ABUSE AND NEGLECT

I. PHYSICAL ABUSE

A. Physical Indicators:

Unexplained bruises and welts:

- ☐ on face, lips, mouth;
- ☐ on torso, back, buttocks, thighs;
- ☐ in various stages of healing;
- ☐ clustered, forming rectangular patterns, reflecting shape of article used to inflict (electric cord, belt buckle);
- ☐ on several different surface areas;
- ☐ regularly appear after absence, weekend or vacation.

Unexplained fractures/dislocations:

- ☐ to skull, nose, facial structure;
- ☐ in various stages of healing;
- ☐ multiple or spiral fractures;
- ☐ bald patches on scalp.

Unexplained burns:

- ☐ cigar, cigarette burns, especially on soles, palms, back, or buttocks;
- ☐ patterns like electric burner, iron, etc.;
- ☐ immersion burns (sock-like, glove-like, doughnut shaped on buttocks or genitalia);
- ☐ rope burns on arms, legs, neck or torso;
- ☐ infected burns, indicating delay in seeking treatment.

Unexplained lacerations or abrasions:

- ☐ to mouth, lips, gums, eyes;
- ☐ to external genitalia;
- ☐ in various stages of healing.
- ☐ Other _____

B. Behavioral Indicators:

- ☐ Feels deserving of punishment.

Behavioral extremes:

- ☐ aggressiveness;
- ☐ withdrawal.

- ☐ Wary of adult contact.
- ☐ Apprehensive when other children cry.
- ☐ Frightened of parents.
- ☐ Afraid to go home.

- | | |
|---|---|
| ☐ Reports injury by parents. | ☐ Vacant or frozen stare. |
| ☐ Lies very still while surveying surroundings (infant). | ☐ Responds to questions in monosyllables. |
| ☐ Manipulative behavior to get attention. | ☐ Inappropriate or precocious maturity. |
| ☐ Indiscriminately seeks affection. | ☐ Capable of only superficial relationships. |
| ☐ Poor self-concept. | ☐ Other _____ |

II. PHYSICAL NEGLECT

A. Physical Indicators:

- | | |
|--|--|
| ☐ Underweight, poor growth pattern; e.g., small in stature, failure to thrive; | ☐ Consistent hunger, poor hygiene, inappropriate dress; |
| ☐ Consistent lack of supervision, especially in dangerous activities or for long periods; | ☐ Wasting of subcutaneous tissue; |
| ☐ Abandonment; | ☐ Unattended physical problems or medical needs; |
| ☐ Bald patches on the scalp; | ☐ Abdominal distention. |
| | ☐ Other _____ |

B. Behavioral Indicators:

- | | |
|---|---|
| ☐ Begging or stealing food; | ☐ Extended stays at school (early arrival and late departure); |
| ☐ Rare attendance at school; | ☐ Delayed speech; |
| ☐ Constant fatigue, listlessness or falling asleep in class; | ☐ Inappropriate seeking of affection; |
| ☐ Doesn't change expression; | ☐ Assuming adult responsibilities and concerns; |
| ☐ Alcohol or drug abuse; | ☐ Delinquency (e.g., theft). |
| ☐ Talks in a whisper or whine; | ☐ Other _____ |
| ☐ States there is no caretaker; | |

III. SEXUAL ABUSE

A. Physical Indicators:

- | | |
|--|--|
| ☐ Difficulty in walking or sitting; | ☐ Torn, stained, or bloody under-clothing; |
| ☐ Pain, swelling, or itching in genital area; | ☐ Pain on urination; |
| ☐ Venereal disease, especially in pre-teens; | ☐ Bruises, bleeding or lacerations in external genitalia, vaginal, or anal areas; |
| ☐ Pregnancy; | ☐ Other _____ |
| ☐ Poor sphincter tone; | _____ |

B. Behavioral Indicators:

- | | |
|--|---|
| ☐ Unwilling to change for gym or participate in physical education class; | ☐ Withdrawal, fantasy, or infantile behavior; |
| ☐ Poor peer relationships; | ☐ Bizarre, sophisticated, or unusual sexual behavior or knowledge; |
| ☐ Delinquent or runaway; | ☐ Reports sexual assault by caretaker; |
| ☐ Change in performance in school; | ☐ Other _____ |

IV. EMOTIONAL MALTREATMENT

A. Physical Indicators

- | | |
|---|---|
| ☐ Speech disorders; | ☐ Failure to thrive; |
| ☐ Lags in physical development; | ☐ Hyperactive/disruptive behavior; |
| ☐ Sallow, empty facial appearance; | ☐ Other _____ |

B. Behavioral Indicators

Habit disorders:

- ☐ sucking;
- ☐ biting;
- ☐ rocking.

Conduct/learning disorders:

- ☐ antisocial behavior;
- ☐ destructive;
- ☐ attempted suicide.

Neurotic traits:

- ☐ sleep disorders;
- ☐ inhibition of play;
- ☐ unusual fearfulness.

Overly adaptive behavior:

- ☐ inappropriately adult;
- ☐ inappropriately infantile;

Behavioral extremes:

- ☐ child does not change expression;
- ☐ compliant, passive;
- ☐ aggressive, demanding.

Developmental lags:

- ☐ mental;
- ☐ emotional.
- ☐ Other _____

BEHAVIORAL INDICATORS OF ABUSED CHILDREN

Children who are abused physically or emotionally display certain types of behavior. Many of these are common to all children at one time or another, but when they are present in sufficient number and strength to characterize a child's overall manner, they may indicate abuse. More than simple reactions to abuse itself, these behaviors reflect the child's response to the dynamics of the family and especially to disturbed parent-child interactions. They are mechanisms for survival in a world where children are either unable to fulfill certain basic needs at all, or can fulfill them only by denying, suppressing or exaggerating important parts of themselves. Frequently learned in infancy, these behaviors become a child's "mode of operation" used to cope with the world at large. The behaviors which characterize abused children fall into four categories:

1. Overly compliant, passive, undemanding behaviors aimed at maintaining a low profile, avoiding any possible confrontation with a parent which could lead to abuse. The child has adapted to the abusive situation by trying to avoid any behavior which the abusive parent notices at all.
2. Extremely aggressive, demanding and rageful behaviors, sometimes hyperactive, caused by the child's repeated frustrations at getting basic needs met. In effect, the child has also adapted, by seeking to provoke the needed attention with whatever behavior it takes to get that attention.
3. Role-reversal behavior or extremely dependent behavior in response to parental emotional and even physical needs. Abusive parents have been unable to satisfy certain of their own needs appropriately and so turn to their children for fulfillment. Their failure can produce two opposite sets of behavior in their children. If a parent needs parental attention, the child may be expected to assume this task, and become inappropriately adult and responsible. Other parents, with a need to keep their child dependent, will produce clinging, babyish behavior in the child long after a child in a healthy family would have become more self-reliant.
4. Lags in development. Children who are forced to siphon off energy normally channeled towards growth into protecting themselves from abusive parents may fall behind the norm for their age in toilet training, motor skills, socialization and language development. Developmental lags may also be the result of central nervous system damage caused by physical abuse, medical or nutritional neglect or inadequate stimulation. There may, of course, be organic or congenital causes for such lags in development.

Some abused children live in an uncertain environment where requirements for behavior are inconsistent and unclear. In some families, abuse is frequent and severe enough to be emotionally and physically harmful but insufficient to threaten physical survival. Frequently, discipline is meted out arbitrarily in response to the parent's needs and feelings at the moment, rather than to punish a child for transgressing clear limits. Children may receive some love, affection and security from their parents but are also often frustrated in attempts to fulfill their needs. This inconsistency creates anger and frustration in the child which is frequently expressed indirectly with the parents, or by explosions with others outside the home.

Other abused children learned to do what the abusive parent wants or expects. At the other end of the spectrum from overly aggressive children, some adapt quickly to others' expectations. Unlike children who act out their frustration and rage, these children may have learned not to expect anything in the way of love or support. Their best efforts are directed at voiding conflict which, in the context of the abusive family, can be triggered by expressing almost any kind of personal need, curiosity, anger or playfulness.

BEHAVIORS OF ABUSED CHILDREN IN SELECTED SETTINGS

Because the dynamics of abusive families vary, along with the individual personalities of the parents and children, an abused child's behavior is often sporadic and unpredictable, and a list of behavioral indicators is useful only as a general guide. Often, behavioral indicators draw attention because of drastic changes in patterns of behavior over time. The degree of an abused child's dependence on adults illustrates the point. Abused children have many needs, but because they have few expectations that these needs will be met, often they will not express them. In a safe environment, however, where the child perceives that it is acceptable to express needs, efforts to always "do the right thing" will soon disappear and be replaced by what can seem to be insatiable demands. The following settings and situations permit observations of some behaviors that could indicate past abuse.

Temporary Substitute Care

Depending on the severity of past abuse and the degree of openness permitted in a hospital or foster home, the behavior of abused children may vary. Some may whimper for their parents, while others will respond to the presence of adults who can give them more complete and loving care. If the rules are strict, the passive abused child is likely to be fiercely compliant; if the rules are more relaxed, the child may eventually begin to express the various needs which had been bottled up at home.

With Strangers

Abused children who display more aggressive behavior are likely to be indiscriminately friendly, attaching themselves to any stranger in a search to find someone to fulfill their needs. On the other hand, abused children who tend to be passive in their responses tend to be inhibited, withdrawn and wary of contact with strangers.

Eating

If eating is a specific area of conflict between a child and an abusive parent, any specific departures from the "normal" method of eating for a child that age can indicate abuse. An 18-month-old who is inappropriately neat in eating habits may be responding to an abusive situation in the family; the four-year-old who is totally compliant in eating behavior rather than very controlling of the environment may also be abused.

Playing

Many abused children simply do not know how to play and find no enjoyment in other children or toys. The way children behave in play offers insights about their inner state. A five-year-old who cleans up after every other child in kindergarten likely has some severe restraints on him at home, which could include abuse. Furthermore, many abused children, conditioned to be extra-ordinarily aware of their parents and the danger they present, will tend to be unaware of other children, engaging in little socialization. (Some are also insufficiently able to protect themselves from dangers in the environment, since their parents are the overwhelming subject of their preoccupation.) Abused children may pick frequent fights.

Parents' and Children's Behavior

Dr. Harold Martin of the University of Colorado Medical Center has pointed out, "It is not uncommon for abusive parents to reinforce "bad" behavior that they verbally complain about. If part of the dynamics of the family is that the parents see the child as an extension of the bad part of themselves or that they need to have a scapegoat in the family, they will resist the child's acting "normal" or "good." We've seen this in treatment and intervention programs where the parents sabotage attempts to help the child change his behavior quite unwittingly. Although a parent complains of behavior "X," one sees him reinforcing that behavior as if he needs to have the child acting badly for some reasons which, for the most part, are not conscious."

Ultimately, a list of specific behaviors to identify child abuse is useful only if the family dynamics which produce those behaviors are clearly understood. The behaviors, verbal and physical, indicate both the survival techniques the child has learned in order to exist in the family, and attempts -- frequently inappropriate in kind or intensity -- to get from others what the parents do not provide. The greater the abuse, the less the child will trust other people and the greater the child's difficulty in responding to love and care.

CHILDREN WHO ARE WITHDRAWN

	GENERAL CHARACTERISTICS	NEEDS
<u>BEHAVIOR</u>	-Uncomfortable with others -Gives up easily -Doesn't participate -Seems sad -Sucks thumb or rocks	-Encouragement -Support -Build self-confidence
<u>COGNITIVE</u>	-Passive learner -Doesn't practice new skills -Afraid to try new things	-Don't force participation -Arrange learning situation for him to observe -Provide individual practice sessions -Give plenty of models
<u>SPEECH-LANGUAGE</u>	-Understand what said to them -Rarely speaks -Very soft voice	-Make continuous efforts to communicate -Be a model for other children
<u>SELF-CONCEPT</u>	-Lacks self-confidence -Poor opinion of self -Cling to parent -Annoyed by others getting too close	-Approval, praise -Respect personal boundaries -Approach gradually -Don't force physical contact -Establish routine
<u>SOCIAL</u>	-Ignores others -Aware of surroundings -Avoid facing problems -Passive -Imitates other's play	-Be persistently positive -Allow to observe others play

CHILDREN WHOSE BEHAVIOR IS HYPERACTIVE

	GENERAL CHARACTERISTICS	NEEDS
<u>BEHAVIOR</u>	-Constantly on move -Easily over-excited -Inconsistent behavior -Mood swings -Lack of motor control	-Re-direct activity -Structure environment -Alter passive & active activities
<u>COGNITIVE</u>	-Unable to screen out distractions -Inability to sit for instructions -Loses interest when task becomes difficult -Unable to concentrate	-Uncluttered workspace -Low noise level -Gradually increase difficulties
<u>SPEECH-LANGUAGE</u>	-Understands -Uses language well -Difficulty keeping mind on what saying -Often confuses the meaning of what she/he is saying -Uses alot of body language -Talks fast	-Help she/he keep on subject
<u>SELF-CONCEPT</u>	-Thinks poorly of self -Usually aware of uncontrolled behavior	-Praise
<u>SOCIAL</u>	-Generally friendly -Likes to be helpful -Difficulty playing cooperative games -Unable to wait to take turns	-Gradually develop attributes such as: patient: be second in line, then first, then third, etc. -Gradually increase time involved in cooperative play

CHILDREN WHO BEHAVE AGGRESSIVELY

<u>GENERAL CHARACTERISTICS</u>		<u>NEEDS</u>
<u>BEHAVIOR</u>	-Easily irritated & angered -Reacts with verbal & physical attack -May hurt others without provocation -May seem unable to control -Destructive	-Quiet room workplace -Give alternative for behavior -Point out cues that indicate losing of self control -Redirect energy to construct things -Provide external controls while developing internal controls
<u>COGNITIVE</u>	-Usually enjoys age appropriate skills -Easily distracted -Needs to change activities frequently -Reluctant learners -Fearful of new activities	-Short instructional periods -Structured environment -Non-cluttered learning space -Allow to watch peers do task first -Alter types of tasks
<u>SPEECH- LANGUAGE</u>	-Normal -Uses physical action to communicate -Message often negative	-Give models of positively stated communications
<u>SELF-CONCEPT</u>	-Thinks poorly of self -Destroy own work as "bad"	-Praise -Reassurance
<u>SOCIAL</u>	-Trouble relating to others -Difficulty trusting others -Angry, hostile, defiant -Demanding -Self defeating in social situations	-Encourage peers to play with him -Stay protectively close to ensure success

CHILDREN WHO BEHAVE ANXIOUSLY

	GENERAL CHARACTERISTICS	NEEDS
<u>BEHAVIOR</u>	-Persistent phobias -Suffer from headaches, stomach aches -Easily upset -Nervous habits -Doesn't like changes -Perfectionist -Confuses real/make believe	-Set routine -Clearly state expectations -Highly structured environment -Reassure about fears -Encourage -Praise
<u>COGNITIVE</u>	-Delayed mastery due to reluctance to try -Becomes confused when anxious -Likes repetitive tasks	-Encourage -Reduce distractions and stimulation -Gradually increase difficulties of tasks
<u>SPEECH-LANGUAGE</u>	-Expert talkers -Uses alot of non-verbal signals	
<u>SELF-CONCEPT</u>	-Fearful -Unsure of self and abilities -Overly sensitive to criticism	-Encouragement -Praise -Build self-confidence
<u>SOCIAL</u>	-Prefer younger children or adults -Can sometimes get along well -Gets upset over loud noises -Occasionally aggressive -Dependent on adults -May have abrupt mood swings	

DEVELOPMENTAL INDICATORS OF ATTENTION DEFICIT DISORDER

<u>Age</u>	<u>Behaviors</u>
0-1	History of colic Feeding problems Sleep problems High activity levels Advanced motor development
1-3	Unable to play alone Unable to play with toys Inquisitive or aggressive destruction of toys Unable to watch TV Unacceptable behavior in public places (church, stores) Unable to sit, to be read to Sleep disturbance
3-5	Unable to use coloring books/crayons Unable to use scissors Peer socialization problems Preschool behavior problems High incidence of impulse behavior-- A. Lying B. Stealing C. Arson D. Destruction
5-12	Attention deficit Classroom disruption Poor academic achievement Peer socialization problems Associated Symptoms-- A. Fine Motor Control B. Gross Motor Control C. Learning Disability D. Early delinquency activity
12 and up	Academic failure Peer socialization problems Alliance with fringe groups Antisocial behavior School withdrawal

Developed by Carle Clinic Association Education Department

CHILDREN OF ALCOHOLICS

How They Feel; What Teachers Can Do

Young Children of Alcoholics May:

1. have a special need for approval and affirmation;
2. feel ashamed; sad; unhappy and/or angry;
3. feel they are being criticized when they are not, or be devastated by criticism; they may feel unlikeable and even behave that way;
4. have a need for perfection;
5. have a need to stir things up (being used to chaos and criticism at home, they feel they don't fit in at school and then work to prove it.);
6. try to find some way to gain control of their lives - through silence; people-pleasing; perfection or rebellion;
7. feel responsible for what happens around them - and guilty when anything goes wrong;
8. feel scared and guilty when people are nice to them (if they break down and let out all the awful stuff they feel inside, maybe people won't like them anymore);
9. isolate themselves;
10. respond with anxiety to authority figures and angry people;
11. be fiercely loyal even to abusive parents;
12. find it difficult to talk about how they feel;
13. take a long time to learn to trust;
14. be eager, but afraid, to have fun.

Suggestions for Therapeutic Activities

In what ways is the child missing out on childhood? Therapeutic activities for him or her can focus on helping the child's life to be more balanced. The process should be gradual so that the child does not feel pushed into frightening activities but can relax over time, feel successful and begin to enjoy new things. If he or she does not want to take part in an activity at first, continue to make it available, gently inviting the child to join in. Even the process of being invited can help him or her to feel special.

Teachers should take time to ask the child what he or she likes and wants, and to give choices, whenever possible.

- most children will benefit from sensory activities that have no specific goal and won't be judged by anyone: playdough, mud or sand play (perhaps with props the child can use to work out conflicts in fantasy, and sometimes with a teacher near to acknowledge or give voice to the child's feelings); fingerpaint; blowing bubbles;
- playing with gentle animals (some children may be scared easily): playing in water - washing dolls, etc.
- having begun with sensory activities, the teacher may then move to exercises and games that foster the child's understanding of his or her feelings and body, such as body drawings; stories about feelings; group activities; mask making; etc.
- finally, it will help to give the child opportunities to make choices and to express his or her own needs, wants and opinions. This can take place in daily interactions with teachers, in one-to-one time with a particular teacher, and through special activities as well.

Here are some specific suggestions for working with children who seem to be in the following roles: (Remember, take it slow!)

Quiet:	Singing, dancing, playing with puppets; completing a story or making one up; masks; animals. Cater to child's enthusiasms whenever possible!
Perfect:	Scribble drawings; fingerpainting; active outdoor games; anything not goal oriented.
Rebel:	Tearing newspaper; wadding paper; kicking pillow; large muscle activities; caring for animals; clay; story telling; mask making. The rebel needs to become aware of his or her feelings and then learn it's possible to make choices about expressing them.
Placator and Adjustor	Draw self portrait; look in mirror; dress-up; talk to tape recorder; lead "follow-the-leader", other activities that help the child to have a sense of self (like being interviewed: what's your favorite color? animal? etc.)

HELPING THE CHILD WITH ADHD/ADD

HELP DIAGNOSE

- Be aware of what to watch for (symptoms).
- Keep observational information (notes, ratings, examples of work, etc.).
- Be sensitive when discussing concerns about behavior with parents.
- Cooperate with physicians.
- Be aware of sources of help.

KEEP CALM AND IN CONTROL OF YOURSELF

- Use relaxation techniques to help control anger.
- Get plenty of rest.
- Keep a positive attitude.
- Separate the child from the behavior--ask yourself how you can help the child deal with this.
- Child-proof the environment.
- Have reasonable expectations for the child and for yourself.
- Keep your voice low whenever possible.
- Develop a good sense of humor if you don't already have one!

BUILD THE CHILD'S SELF ESTEEM

- Be as positive as possible with the child
- Give the child specific responsibilities.
- Touch is very important.
- Use encouragement.
- Provide activities that build on the child's needs and interests.
- Look for the best in the child--find something to like.
- Accept differences in approach.
- Deal appropriately with medication issues if necessary.

MANAGE BEHAVIOR

- Have consistent routines.
- Structure the environment (home, school, or day care).
- Provide an appropriate balance of child-directed and adult-directed activities.
- Reduce waiting.
- Have a good daily schedule that alternates active and quiet activities.
- Provide many creative and stress-reducing activities and materials (water play, play dough, woodworking, and gross motor activities are great).
- Plan ahead to avoid problem situations whenever possible.
- Provide a quiet place for the child to get away from it all if he/she becomes overstimulated.
- Recognize the child's limits.
- Avoid overstimulation.
- Have all the adults working with the child be consistent.
- Don't say "don't" whenever possible. State directions in a positive way.
- Keep the child physically near you.
- Teach and practice appropriate social skills.
- Have a few simple UNBREAKABLE rules and consistently enforce them.
- Use direct, simple commands.
- Give one direction at a time.
- Allow adequate time for compliance.
- Don't dialog--act.
- Don't wear yourself out over minor issues--save your energy for the important ones.

- Have the child repeat commands to you.
- Use physical direction.
- Make sure you have the child's attention when speaking to her/him.
- Use eye contact.
- Use lots of gross motor activities (free play outside is the best).
- Avoid excessive punishment.
- Help the child so see how his behavior affects others.

HELP THE OTHER CHILDREN

- Enlist their help in dealing with the child with ADHD.
- Protect other children from the physically aggressive child.
- Reinforce the other children for interacting with the child with ADHD.
- Don't punish the whole group for something the ADHD child did.

WORK WITH THE FAMILY

- Remember that the family with an ADHD child is dealing with the same issues as any other family with a child with a disability.
- Communicate frequently with parents--not just when there is a problem.
- Help parents to see the child's strengths and interests.
- Temper all negatives with positives.
- Provide parents with information about child development and behavior management techniques.
- Reinforce the parent-child relationship.
- Reinforce good parenting practices.
- Encourage parent involvement.

HELP MANAGE MEDICATION

- Observe how medication affects the child.
- Help parents to identify whether or not the medication is helping.
- Note how long it takes for a medication to take hold and how long it remains effective.
- Keep track of what times of the day are more difficult for the child.
- Support the parents' decision to use or not to use medication--don't belittle them for it.
- Keep track of when and how much medication is administered.

Section VI - *Glossaries*

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Glossary of Terms and Abbreviations

GLOSSARY OF SPECIAL NEEDS TERMS

ABDUCTION: Movement of a limb outward from the body.

ACCELERATION: Increasing the frequency of a behavior.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS): A disease caused by a virus (human immunodeficiency virus, or HIV) that destroys a person's defenses against infection. There is no known cure at the time of this writing.

ADAPTIVE BEHAVIOR: Behaviors required in specific settings which permit the child to function appropriately.

ADAPTIVE DEVICE: Any piece of equipment designed to assist the child's use of a body part.

ADDUCTION: Movement of a limb inward.

ADVENTITIOUS HANDICAP: A handicap that develops any time after birth.

AFFECTIVE BEHAVIOR: Behaviors that convey attitudes, values, personal responsibility, motivation and healthy self-respect.

AFFRICATE (sound): Consonants for which there is a complete stoppage of the outgoing breath stream followed by a relatively slow, turbulent release: ch, j.

AGE-EQUIVALENT SCORE (A.E.): A way of reporting test scores in which the score is equal to that of an average child of that age, i.e. an age equivalent score of 3.7 means that the child did as well as an average child who is 3 years and 7 months old.

ALLERGEN: A substance that brings on an allergic reaction.

ALVEOLARS: Consonants produced by placing the tongue on or close to the gum ridge just behind the upper teeth: t, d, n, l, s, z.

AMBLYOPIA: Reduced vision (20/30 Snellen or less). Vision in these cases is not easily improved. If the condition is discovered and treated early (especially in children aged less than ten), the probable outcome of the condition will generally be better.

AMNIOCENTESIS: The insertion of a needle into the amniotic sac in order to obtain fluid which will show evidence of chromosomal abnormalities.

ANISEIKONIA: A condition in which one eye sees an object as one size and shape and the other eye sees the same object as a different size and shape.

ANOMALY: Abnormality

ANOXIA: A complete lack of oxygen.

ANTIBIOTIC: A substance prescribed by a physician or dentist to kill or slow the growth of certain bacteria. Usually taken by mouth, antibiotics should always be taken for the prescribed length of time. No antibiotics affect viruses.

ANTICIPATORY EXCITEMENT: Showing movement or behavior change in response to expecting or being ready for something to happen. Example: Child smiles and waves hands while waiting to be picked up.

ANTICONVULSANT: Medicine used to control seizures. The amount to administer must be calculated on the patient's body weight.

APHASIA: Impairment of the ability to use or understand spoken language.

Glossary of Terms and Abbreviations

APRAXIA: The lack of praxis or motor planning. When a child has a sensory integrative problem in which they have trouble carrying out a task involving a sequence of motor behaviors. For example, getting out of a box or riding a bike.

ARTICULATION DISORDER: A speech impairment in which a child's production of speech sounds is substantially different from that of other children who are the same age and who speak the same language and dialect. Sounds may be left out or distorted, extra sounds may be added, or some sounds may be substituted for others.

ASPHYXIA: A lack of oxygen usually caused by interruption of respiration; can cause unconsciousness and/or brain damage.

ASTHMA: A chronic illness in which the bronchioles, or small windpipes, are "twitchy" or overreact compared to those of the average person. The bronchioles become temporarily narrowed or blocked when they overreact in response to various triggers or stimuli such as viral respiratory infections or allergens.

ASTHMA ATTACK: Any episode or flare of asthma in which worsening of breathing interrupts ongoing activities or requires some intervention such as rest or medication, before one can resume normal and comfortable breathing.

ASTIGMATISM: A condition that causes blurred vision at all distances. Children who have astigmatism may complain of headaches and tire easily.

ASYMMETRICAL: Unequal, lack of similarity in form between two sides of the body.

ATAXIC: Unbalanced and jerky. Ataxic movements are characteristic of one type of cerebral palsy.

ATHETOID: Moving uncontrollably and continuously. Muscles may be tense and rigid or loose and flacid. Athetoid movements are characteristic of one type of cerebral palsy.

ATTENDING BEHAVIOR: Ability to pay attention to a task. Attending behavior includes alertness, stimulus selection, focusing and vigilance.

ATTENTION DEFICIT DISORDER (A.D.D.): A syndrome characterized by a short attention span, inability to follow a series of directions, and impulsivity which may or may not be accompanied by hyperactivity. Onset is before age 6.

AUDIOGRAM: A graph which indicates the level of hearing loss at various frequencies.

AUDITORY DISCRIMINATION: Being able to hear the differences between sounds.

AUDITORY PERCEPTION: The ability to interpret or organize information coming in through the ear.

AUTISM: Disorder characterized by an inability to interact with others, perseveration to tasks, abnormal language development, self-stimulatory behaviors.

AUTOMATIC MOVEMENTS: Necessary movements done without thought or effort.

BALANCE: Ability to keep steady positions.

BASELINE: An objective measure which is used to determine the child's level of functioning on specific tasks before intervention and can be used to plot progress.

BEHAVIOR: Any action of a person.

BEHAVIOR MODIFICATION: A method of

Glossary of Terms and Abbreviations

assisting children to learn skills and social behavior through rewards and natural consequences.

BENIGN: Refers to a tumor or growth that can destroy tissue by pressing on it or by filling a body of space required by another organ.

BILABIALS: Consonants produced by bringing the lips together: p, b, m, w.

BILATERAL: Includes both sides.

BIMANUAL: Two handed.

BINOCULAR VISION: The ability to use the two eyes together to focus on an object and blend the two images into a single image.

BLEPHARITIS: Inflammation of the eyelids. Associated with itchiness, redness, tearing and a gritty feeling. May be accompanied by a discharge of mucous or pus, which collects on the lids (especially the lashes), and in the tear sacs.

BLIND, EDUCATIONALLY: Totally without sight or having so little sight that all learning must depend upon senses other than vision.

BLIND, LEGALLY: Visual acuity of 20/200 or less in the better eye after correction with lenses.

BODY AWARENESS: Knowledge of one's body, in terms of its different parts and their relation to one another.

BOLSTER: A long, narrow, rounded pillow or cushion. They come in a variety of sizes and fabrics. A pillow rolled over and tied makes a good bolster.

BRAILLE: A system of writing letters, numbers, and other language symbols by a combination of six raised dots.

BRAIN INJURY: Injury or damage to some part of the brain. Occurs before, during, or after birth.

BUPHTHALMOS: Large eyeball. Associated with infantile glaucoma.

CATARACT: A clouding of the lens of the eye, which reduces the amount of light received at the retina. Useful vision may be completely blocked out, depending upon the location of the cataract and how dense it is. Cataracts can be removed, and glasses or contact lenses can be substituted for the cloudy, natural lens.

CAUSALITY: A developmental step which is seen when a child indicates through physical movement or language that he/she understands that one action can cause something to happen.

CENTRAL NERVOUS SYSTEM: The neural tissue that makes up the brain and spinal cord and is responsible for intellectual activity and voluntary movement.

CEREBRAL PALSY: Disorder of posture, muscle tone, and movement, resulting from brain damage.

CHOREOATHETOSIS: Type of cerebral palsy in which there are uncontrolled muscle movements in all four limbs of the body and sometimes in the face.

CLEFT PALATE: A condition present at birth in some infants, in which the roof of the mouth (palate), has a narrow opening (cleft), which can interfere with speech or feeding. This condition is usually improved through a series of surgical procedures.

CLONUS: Seizures characterized by rapidly alternating muscular contraction and relaxation.

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CO-CONTRACTION: The simultaneous contraction of all the muscles around a joint to stabilize it.

COGNITION: The act or process of knowing or thinking.

COLOR DEFICIENCY: Reduced ability to perceive differences in color. Usually involves subtle differences in reds and greens.

CONDUCT DISORDER: A group of behavior disorders including disobedience, fighting, and temper tantrums beyond that expected from the average child at age appropriate levels.

CONDUCTIVE HEARING LOSS: Occurs when there is a problem in the outer or middle ear (the mechanisms that carry sound to the inner ear). They are usually less severe than sensorineural hearing losses and can usually be reduced or eliminated through medical treatment. The most common cause is infections that fill the ear with fluid.

CONGENITAL: Refers to a disease or condition that is present at birth, and that is not necessarily caused by inheritance.

CONJUNCTIVITIS: Inflammation of the conjunctiva, which is the membrane lining the eyelid and covering the front part of the eyeball. Sometimes associated with blepharitis.

CONSONANT CLUSTER: Two or more consecutive consonants in the same syllable.

CONSONANT SINGLETON: A single consonant which occurs before or after a vowel in a syllable.

CONTRACTURE: Permanently tight muscles and joints.

COORDINATION: Harmonious functioning of muscles or groups of muscles in movement.

CRANIAL NERVES: Twelve nerves that connect the brain with the muscles and sense organs of the face, neck, eyes, ears, nose, and mouth.

CRAWL: Movement forward, child's stomach on floor. Child moves legs in alternate way (moves one, then the other).

CREEP: Movement forward on hands and knees, stomach up. Child moves one hand and opposite knee, then other hand and opposite knee, and so on.

CRITERION: A definition of the behavior the child is to do. A criterion should be stated in a very specific way so you can decide whether or not the child does the behavior. This decision allows you to see if your teaching is or is not changing a behavior.

CUE: Something you do to get the child to behave or respond in a certain way. Cues can be verbal or physical. Example: verbal cue: "Come here, Tommy." physical cue: touching the child behind the knee to get him to lift leg to take a step or guiding child's hand to lift spoon to mouth.

CYANOSIS: A condition in which a lack of oxygen in the blood causes the blood to be darker and the skin to be bluish.

CYSTIC FIBROSIS: An inherited disorder that causes severe, long-term respiratory difficulties; no cure is currently available.

DEAFNESS: A hearing loss that is so severe that children cannot use their hearing for learning even with the use of a hearing aid.

DECIBELS: Unit for expressing the loudness of

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sound on a logarithmic scale.

DEFORMITY: A body malformation or distortion in which the body or limbs are fixed in abnormal position.

DEGENERATIVE NEUROLOGICAL DISEASE: A condition that progressively destroys parts of the nervous system. This means that the symptoms of the condition become worse as time passes.

DEPRESSION (clinical): Refers to an illness in which a chemical imbalance is present in the brain chemistry. The resulting action is an impairment in ability to handle emotions and feelings. Newest research is proving that depression may be an inherited disease. Most depression is treated with medication.

DEVELOPMENTAL DELAY: An overall slower rate of development in gross motor, fine motor, self-help, cognitive, social, and/or adaptive behavior skills.

DEVELOPMENTAL DISABILITY: Term preferable to mentally retarded, may include children who are developmentally delayed due to environment, particularly in the preschool years.

DEVELOPMENTAL MILESTONE: A behavior normally seen in most children at a particular time.

DIGIT: Finger or toe.

DIPLEGIA: Condition of cerebral palsy with major involvement of the legs and minor involvement of the arms.

DYSPRAXIA: Poor praxis or motor planning. A less severe, but more common dysfunction than apraxia, it is often related to poor somatosensory processing.

DISTRACTIBLE: Not able to concentrate.

DOWN SYNDROME: A genetic disorder characterized by slow cognitive development, epicanthic folds, short stubby fingers, and a straight crease across the palm.

DYSLEXIA: A disturbance in the ability to read or learn to read.

DYSTROPHY: Weakness and degeneration of muscle.

EARLY INTERVENTION: Early educational and therapeutic services designed to meet the needs of the child at risk from birth to age five.

ECHOLALIA: The repetition of what other people are saying; characteristic of children with mental retardation, autism, and severe behavior disorders.

ECZEMA: A dry, scaling condition of the skin, usually the result of allergy.

EDUCABLE MENTALLY HANDICAPPED/RETARDED: EMH or EMR designates the class of mental retardation characterized by slow mental development which is slightly below average. With assistance, these children are generally able to function in regular classrooms and to participate fully in the community.

EDEMA: Swelling of the body caused by excess of fluid in the tissues.

ELECTROENCEPHALOGRAPH: An instrument for recording and measuring electrical energy generated by the brain.

ENCOPRESIS: A condition in which children continue to soil their pants after toilet-training.

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ENURESIS: A condition in which there is uncontrolled urination:

diurnal enuresis:- wetting occurs in the daytime.

nocturnal enuresis- wetting occurs at night.

EPILEPSY: see SEIZURE DISORDER

EQUILIBRIUM: Balance.

ETIOLOGY: The origin or cause of a disease.

EXTENSION: Straightening of trunk and limbs of the body.

EXTENSOR PATTERN: Tendency to straighten the whole body when startled.

EXTINCTION: Behavior modification procedure in which reinforcement of behavior is withheld and the behavior is gradually decreased or seldom occurs.

EYE DOMINANCE: Tendency of one eye to do most of the seeing, with help from the less dominant eye.

FACILITATION: Teacher's role in the guidance of children's learning through planning and curriculum development where the child is expected to be an active participant in the process.

FAILURE TO THRIVE: A situation in which a combination of health and/or psychological factors results in a child's inability to gain weight and grow.

FAMILIAL DISEASE: Refers to a disease or condition that runs in a family.

FEBRILE SEIZURE: A seizure caused by a rapidly rising fever. They are brief and do not necessarily indicate that a child has epilepsy.

FETAL ALCOHOL SYNDROME: A disorder

caused by alcohol abuse in the mother during gestation; characterized by slow mental development and specific facial features.

FIELD OF VISION: The entire area that the eye can see without shifting position from straight ahead.

FINE MOTOR: Small muscle movements; use of hands and fingers.

FIXATE: To look at or stare at; to focus eyes on something.

FLEXION: Bending of elbows, hips, knees, etc.

FLOPPY: Loose or weak posture or movements.

FOCAL SEIZURE: A seizure where there is jerking in a single limb or one side of the body.

FORM CONSTANCY: The ability to recognize an object or shape, regardless of what position or angle it is viewed from.

FREQUENCY (OF SOUND): Refers to the pitch of a sound. All the sounds around us come in different pitches. For example, a man's voice is low pitched (low frequency) and a child's voice is high pitched (high frequency).

FRICATIVE (sound): Consonants for which the articulators are loosely approximated so that turbulence is created in the outgoing breath stream: f, v, s, z, sh, sz as in *leisure*, th as in *bath*, th as in *this*, h.

GENES: The parts of the chromosome that direct the way in which body tissue develops.

GESTURE: A physical movement or motion. Example: Child hold hands up to be picked up.

Glossary of Terms and Abbreviations

GLIDES: Prevocalic consonants characterized by a rapid movement of the articulators from a high front or back tongue arch to the vowel that follows: w, j.

GLAUCOMA: A condition in which the normal fluid of the eye does not drain off properly, causing increased pressure within the eye. This pressure causes damage to the optic nerve, resulting in severe loss of sight or tunnel vision.

GRAND MAL SEIZURE: see SEIZURE DISORDER

GRAVITATIONAL INSECURITY (GRAVITY BOUND): An unusual degree of anxiety or fear in response to movement or change in head position; related to poor processing or vestibular and proprioception information.

GROSS MOTOR: Large muscle movements, like walking, sitting, crawling.

HABILITATION: Provision of education to facilitate learning.

HABITUATION: Stimulus which has lost its ability to attract the child's interest.

HANDLING: Holding and moving a child's body, with or without the help of the child.

HEAD CONTROL: Ability to control the position of the head.

HEARING IMPAIRMENT: A disorder which may range from very mild to severe. The child who has a mild hearing loss may learn with very little intervention; the child who has a moderate loss may learn auditorily but with a hearing aid; the child who has a severe hearing loss will need special education services to facilitate language and speech development.

HEART MURMUR: A sound made by the action of the heart when the valves between the heart chambers do not close completely.

HEMIPLEGIA: Condition of cerebral palsy with major involvement of one side of the body.

HEMOPHILIA: An inherited condition affecting males, in which the blood plasma contains an insufficient quantity of the factor needed to clot blood.

HEREDITARY: Refers to a disease or condition that is passed from parents to child or grandchildren.

HIGH RISK INFANT: A child who, for genetic, sociological, or health reasons may face developmental delay.

HYDROCEPHALUS: Condition in which the head is enlarged and the brain has excess fluid in the four ventricles in the middle of the brain.

HYPERACTIVITY/HYPERKINESIS: Excessive physical/muscular activity characterized by excessive restlessness and mobility; sometimes associated with learning disabilities.

HYPEROPIA: Also called farsightedness, a condition resulting in a blurred image for near vision. Easily corrected by glasses.

HYPERTONIC: Abnormally high muscle tone or tension; tightness of muscles.

HYPOTONIC: Abnormally low muscle tone or tension; floppy muscles.

HYPOXIA: A deficiency in the amount of oxygen reaching bodily tissues.

IMITATE: To copy; to do the same as someone else.

Glossary of Terms and Abbreviations

IMPULSIVITY: Urge to perform a certain activity; not controlled by reason.

INDEPENDENT(LY): Without assistance or support. Used in teaching programs to show that a child is able to do something alone with no additional help.

INDIVIDUALIZED EDUCATIONAL PROGRAM (IEP): An educational plan written for each child with identified special needs.

INDIVIDUAL FAMILY SERVICE PLAN (IFSP): An educational plan written by a team of professionals and the parents of a child up to age three with identified special needs.

INTERDENTALS: Consonants produced by placing the tongue between the front teeth: th as in thing, and th as in this.

INTERDISCIPLINARY TEAM: Refers to an intervention team in which the roles of the individual team members must be coordinated with the other members of the team.

INVERSION: Turning in.

INVERTED: Upside down.

INVOLUNTARY MOVEMENTS: Unintended movements.

JAUNDICE: A yellowish tinge or color of the skin, usually caused by problems in the liver.

JUVENILE DIABETES MELLITUS: A child's disease characterized by inadequate insulin production in the body; controlled with diet and/or medication.

KINESTHETIC AWARENESS: Awareness of the body's movement; determining one's own body position without looking; dependent on proprioception.

KINESTHETIC LEARNER: A child who learns best through the use of his sense of touch and position.

LABIALS: Consonants in which the lips are used to block or constrict the outgoing breath stream: p, b, m, w, f, v.

LABIODENTALS: Consonants produced by touching the lower lip to the upper teeth: f, v.

LANGUAGE DISORDER: Includes problems in understanding and in using spoken language. Children with language impairments may have problems in several or all aspects of language: vocabulary, combining words to make sentences; as well as their use of specific rules of language.

LEARNING DISORDER/DISABILITY: A difficulty learning to read, write, compute, or do school work that cannot be attributed to impaired sight or hearing, or to mental retardation.

LEAST RESTRICTIVE ENVIRONMENT: Prescribed by law as the setting where the child is able to learn and develop in an environment which best meets his needs and is as close to a normal setting as possible.

LIGHT PERCEPTION: The ability to distinguish light from dark.

LIQUIDS: Consonants for which the articulators make only partial, frictionless approximation: r, l.

LOW VISION: Vision so limited that special education services are necessary; child can learn through the visual channel.

LEUKEMIA: A condition in which there is an abnormal increase in the number of white blood cells present in the blood. Also called cancer of the blood.

Glossary of Terms and Abbreviations

MAINSTREAMING: Practice of integrating children with special needs into regular classes for all or part of the school day.

MAINTAIN: To hold or keep in place.

MALIGNANT: Refers to a tumor or growth that destroys other tissue as it grows. Usually means that the tumor or growth is cancerous.

MENINGOCELE: Type of spina bifida in which the the covering of the spinal cord protrudes through an opening in the vertebrae but the cord itself and the nerve roots remain enclosed.

MICROCEPHALUS: A condition characterized by an abnormally small skull with resulting brain damage and mental retardation.

MIDLINE: The middle of the body from top to bottom. Imagine a line drawn from the top middle of the head, over the nose, and down the middle of the body.

MINIMAL BRAIN DYSFUNCTION: A medical term used to indicate a delay or disorder in the ability to perform sensory or motor functions appropriately.

MODELING: A visual or auditory demonstration provided by the teacher or other students which allows for a child to learn through indirect means.

MODALITY: The way (sight, hearing, touch) a person learns.

MODULATION: The brain's regulation of its own activity. Modulation involves facilitating some neural messages to maximize a response, and inhibiting other messages to reduce irrelevant activity.

MONOPLEGIA: Paralysis affecting one limb.

MOTOR CORTEX: The surface of the brain that controls the muscles of the trunk, arms, and legs.

MOTOR PATTERNS: The ways in which the body and limbs work together to make movement possible.

MOTOR PLANNING: See PRAXIS.

MUSCULAR DYSTROPHY: A group of diseases that gradually weaken muscle tissue, usually becoming evident by age four or five.

MYOCLONIC SEIZURE: A type of seizure in which there are short isolated jerks of the muscles.

MYOPIA: Also called near-sightedness; a condition resulting in blurred vision. Easily corrected by glasses.

MYRINGOTOMY: An incision made in the ear drum to drain fluid from an infected ear.

MYRINGOTOMY AND TUBES: A "bobbin" of plastic is inserted in the incision to allow air to enter the middle ear and assist in the drainage of fluid.

NASALS: Consonants produced by blocking the oral cavity and emitting the sound through the nose: m, n, ng.

NEBULIZER: A device which turns liquid into a spray.

NECK FLEXION: Bending of the neck.

NEGATIVE REINFORCEMENT: Negative or punishing outcome to a specific behavior.

NEUROLOGICAL DYSFUNCTION: The inability to perform sensory or motor functions appropriately.

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NEUROLOGICAL EXAMINATION: A special kind of physical examination that checks how well a person's nervous system works.

NORMALIZATION: Providing opportunities for all children to experience life with their peers.

NYSTAGMUS: Involuntary rapid, rhythmic eye movements. This usually occurs in combination with a visual disability. The eye movements are usually side to side and continuous.

OBJECTIVE: What it is we want to teach.

OCCUPATIONAL THERAPY: Treatment given to improve movement for daily living.

OPTIC ATROPHY: A condition in which the optic nerve is damaged. Color vision may be affected along with visual acuity.

ORIENTATION AND MOBILITY INSTRUCTOR: A specialist who provides a disabled child with the concepts and skills needed to understand and move about safely and easily.

ORGANIC: Used to describe a condition resulting from a disease or damage to an individual's body.

OTITIS MEDIA: An infection or inflammation of the middle ear which can cause conductive hearing loss.

PALATAL (sound): Consonants for which the tongue is raised toward the hard palate: sh, j, ch, sz as in leisure.

PARALLEL PLAY: Playing alongside, but not with other children, while playing with the same things.

PARAPLEGIA: Condition of cerebral palsy with major involvement in the legs.

PASSIVE: Not participating, acting, or operating.

PATHOLOGICAL: Pertaining to or caused by a disease.

PERCEPTION: Organizing or interpreting information.

PERCEPTUAL HANDICAP: The inability to interpret stimuli received through the senses despite adequate vision, hearing, and other sensory processes.

PERCEPTUAL-MOTOR: Coordination and body movements with the senses of sight, hearing, and touch.

PERINATAL: Occurring at or immediately after birth.

PERIPHERAL VISION: The ability to perceive the presence, motion, or color of objects that are outside the direct line of vision (egs. to the side).

PERSONALITY DISORDER: A group of behavior disorders.

PERSEVERATION: Continuation of a behavior beyond the time and situation in which the behavior is appropriate.

PHONEME: A smallest segment of sound that can be distinguished.

PHYSICAL THERAPY: Programs for promoting self-sufficiency primarily related to gross motor skills.

PHYSICAL CUE: A tactile cue employed throughout physical manipulation which facilitates an appropriate response.

Glossary of Terms and Abbreviations

PHYSICAL PROMPT: The child is physically manipulated toward or through the correct response in the presence of a stimulus.

POSITIVE REINFORCEMENT: A positive response to a behavior which encourages the child to repeat the behavior.

POST-ICTAL SLEEP: The sleep that occurs naturally after seizures. It may last for a few minutes to a few hours.

POSTNATAL: Occurring after birth.

POSTURE: The position or attitude of the body or of the body parts.

POSTVOCALIC: The sound following a vowel in a syllable.

PRENATAL: Occurring before birth.

PREREQUISITE: Something required or needed before going on to something else. Used in teaching programs to show that certain programs or activities should be done or the child should have certain skills or behaviors before teaching a new program or activity.

PREVOCALIC: The sound in a syllable preceding the vowel.

PRIMITIVE MOVEMENTS: infantile movements.

PRONATION: Turning of the palm downward or backward.

PRONE: Lying on the belly.

PROPRIOCEPTION: Perception of sensation from the muscles and joints. Proprioceptive input tells the brain when and how the joints are bending, extending, or being pulled or com-

pressed. It lets the brain know where each part of the body is and how it is moving.

PROTHETIC DEVICE: Artificial limb. Also called prosthesis.

PSYCHOMOTOR SEIZURE: A type of seizure in which the person displays inappropriate behavior for the setting and automatic or involuntary movements or actions.

PSYCHOSIS: A severe mental disorder with or without organic brain damage, characterized by deterioration of normal intellectual and social functioning and by partial or complete withdrawal from reality.

PYLON: A primitive, artificial appliance used to replace a limb or a portion of a limb.

QUADRIPEGIA: Condition of cerebral palsy with major involvement of arms and legs.

REFLEXES: Postures and movements completely out of child's control.

REGRESSION: Return to less mature behaviors, can be physical, social, or emotional.

REINFORCEMENT: Any consequence to an action which increases the probability that the individual will repeat the action.

REMISSION: Period during which the symptoms of a condition disappear for an unpredictable period of time.

REPRESENTATIONAL PLAY: When children use symbols to represent their play behaviors; play has more of a beginning, middle, and end.

RESOURCE ROOM: A specialized learning environment where individualized attention is received.

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RETINAL DETACHMENT: An eye condition in which a hole in the retina has allowed fluid to leak in behind the retina and push the retina off the back of the eye. Significant amounts of vision will be lost.

RETINITIS PIGMENTOSA: A condition in which the retina functions progressively worse throughout life. Side vision is usually decreased before central vision. Color blindness and night blindness are common symptoms of this disturbance.

RETROLENTAL FIBROPLASIA (RFP): A disease of the retina in which a mass of scar tissue forms in back of the lens of the eye. The disease usually affects both eyes. In severe cases there is complete loss of sight.

RIGHTING: Ability to put in or restore the head and body to a proper position when in an abnormal or uncomfortable posture.

RIGIDITY: Very stiff movements and posture.

ROTATE: To turn or cause to turn.

ROTATION: Turning or spinning on an axis.

RUBELLA: German or three-day measles. Rubella is usually mild, but it can seriously harm a baby whose mother is infected early in her pregnancy.

SCHIZOPHRENIA: An illness in which a chemical imbalance is present in the brain chemistry. The resulting action is withdrawal from reality with highly variable accompanying affective, behavior, and intellectual disturbances. This illness is treated with medication and current research indicates that the disease may be genetic.

SCREENING: A term used to describe abbrevi-

ated testing procedures in a variety of disciplines.

SEIZURE DISORDER (Also called EPILEPSY): GRAND MAL: condition characterized by periods of loss of consciousness, jerking muscles, prolonged staring into space, rolling eyes, dilated pupils, and incontinence; **PETIT MAL:** milder form characterized by staring into space and short term loss of consciousness; child may be unaware that he has experienced a seizure. Both forms may be controlled with medication.

SENSORI-NEURAL HEARING LOSS: Occurs when there is a problem in the inner ear or with the nerves that carry sound to the brain. This kind of loss is permanent and more severe than a conductive hearing loss.

SENSORIMOTOR PLAY: Play which revolves around the use of the senses and is not dependent on language; a method of playing which is most often seen in children between birth and age two and a half.

SENSORY INPUT: The streams of neural impulses flowing from the sense receptors in the body to the spinal cord and brain.

SENSORY INTEGRATION: The organization of sensory input for use. The working together of the various parts of the nervous system in order to respond to the environment, learn something, perform some action, etc.

SENSORY INTEGRATIVE DYSFUNCTION: An irregularity or disorder in brain function that makes it difficult to integrate sensory input effectively. Sensory dysfunction may be present in motor, learning, social/emotional, speech/language, or attention disorders.

SENSORY MODALITY: Refers to any one of

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the five sensory avenues for receiving information: seeing, hearing, touching, tasting, smelling.

SEQUENCE: An order of steps; a series.

SEVERE/PROFOUND MENTAL RETARDATION: The inability in a child to perform even simple tasks without assistance; child functions on a sensori-motor level.

SEX-LINKED CONDITION: A condition that is passed from parent to child through a sex chromosome. A parent may be a carrier of a condition without having it herself.

SHAPING: A procedure used to teach new behaviors. The child is reinforced for doing behaviors that are closer and closer to the final goal or desired behavior.

SHUNT: Tube implanted to drain excess fluid from the brain to another part of the body.

SIBILANT (sound): Consonants which can be described as hissing sounds: s, z, sh, ch, j, sz as in leigure.

SOMATOSENSORY: body sensations that are based on both tactile and proprioceptive information.

SPASM: Sudden tightening of the muscles. Spasms are characteristic of one kind of cerebral palsy.

SPASTICITY: Tightness.

SPINA BIFIDA: A disorder which occurs prior to birth in which the spinal cord is unprotected; causes difficulty with paralysis, loss of bowel and bladder control, and possibly cognitive development.

STAFFING: A meeting at which the educa-

tional staff, the administrative staff, the evaluation team staff, and when possible the parents of a child, discuss the child's educational program.

STOMA: Opening in the abdominal wall, created through surgery, to allow the urine from the kidneys to drain into a collecting bag.

STOPS: Consonants for which there is a complete stoppage of the outgoing breath stream, usually followed by an abrupt release: p,b,t,d,k,g.

STRABISMUS: A condition in which the eye turns or squints, due to a muscle or sight disturbance. Vision may be lessened in the squinting eye. If the eye is turned toward the nose, the condition is called esotropia. If the eye is turned away from the nose, the condition is called exotropia.

STRADDLE: To sit on top of something, a leg on either side.

STRATEGY: A method or technique; a plan of action used to do something.

STRIDENT: Consonants characterized by considerable noisy turbulence caused by forceful air flow striking the back of the teeth: f, v, s, z, sh, ch, j, sz as in leigure.

STUTTERING: A disorder which affects the fluency of speech; may involve prolongations, repetitions, facial grimaces, muscle tension and other physical behaviors.

SUPINE: Lying on the back.

SYMMETRICAL: Similarity in form between two sides of the body.

SYNDROME: A set of signs or symptoms that occur together repeatedly in a number of cases.

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SYSTEMIC: Refers to a disease that can exist throughout the body. Arthritis is an example of a systemic disease.

TACTILE AWARENESS: Awareness of sense of touch.

TASK ANALYSIS: Breaking down a complex task (such as an educational objective) into simpler, smaller parts.

TACTILE DEFENSIVENESS: A sensory integrative dysfunction in which tactile sensations create negative emotional reactions (like a fingernail scraping across a blackboard). It is associated with distractibility, restlessness, and behavior problems.

TEAM EVALUATION: An interdisciplinary appraisal of a child's functioning in a variety of areas such as motor skills, speech and language, cognitive, adaptive, and behavior.

TIME OUT: Removal from or being taken away from all opportunities to get reinforcement.

TONE: Firmness of muscles.

TONIC NECK REFLEX: Uncontrollable movement in which turning of the head causes one arm to straighten and stiffen, and the other to bend.

TOTAL COMMUNICATION: Utilization of signs, speech, auditory training, and lip reading to communicate with a child.

TOXIN: A substance that acts like a poison.

TRACHEA: The windpipe, which leads from the back of the throat to the lungs.

TRAUMA: A blow or injury.

TRIAL: A try, a test, an attempt. Used in teaching to refer to each time you present the cues and materials to your child to teach a particular behavior.

TRUNK: The body, not including the head and the arms and legs.

TRUNK CONTROL: Ability to bring body in a straight, upright position when tilted in any direction.

VELARS: Consonants produced by arching the back of the tongue to make contact with the soft palate: k, g, ng.

VERBAL PROMPT: A verbal direction given to initiate a behavior.

VESTIBULAR SYSTEM: The sensory system that responds to the position of the head in relation to gravity and accelerated or decelerated movement; it integrates neck, eye, and body adjustments to movement.

VISUAL ACUITY: Sharpness of vision.

VOLUNTARY MOVEMENTS: All the muscles in the body in which there is conscious control over the contraction.

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GLOSSARY OF ABBREVIATIONS

AAMD: American Association for Mental Deficiency	CCC-SP: Certificate of Clinical Competence-Speech Pathology
ABIC: Adaptive Behavior Scale for Children	CDS: Child Development Specialist
ABS: Adaptive Behavior Scale	CEC: Council for Exceptional Children
ACLD: Association for Children with Learning Disabilities	CELF: Clinical Evaluation of Language Functions
ACSW: Accredited Certified Social Worker	CHASI: Children's Home and Aid Society of Illinois
ADD (AD-HD): Attention Deficit Disorder (Attention Deficit-Hyperactivity Disorder)	COA: Child Of an Alcoholic
AIDS: Acquired Immune Deficiency Syndrome	CP: Cerebral Palsy
ARC: Association for Retarded Citizens	CVA: Cerebral Vascular Accident
BA: Bachelor of Arts	DCFS: Department of Children and Family Services
BD: Behavior Disorder	DD: Developmentally Delayed or Developmentally Disabled
BDI: Battelle Developmental Inventory	DDST: Denver Developmental Screening Test
BPD: Bronchopulmonary Displasia	DIAL-R: Developmental Indicators for the Assessment of Learning-Revised
BS: Bachelor of Sciences	DMHDD: Department of Mental Health and Developmental Disabilities
BSID: Bayley Scales of Infant Development	DORS: Department of Rehabilitation Services
BSN: Bachelor of Science in Nursing	DOB: Date Of Birth
BSW: Bachelor of Social Work	DSCC: Division of Services for Crippled Children
CA: Chronological Age	EEG: Electroencephalogram
CAEYC: Chicago Association for the Education of Young Children	EKG: Electrocardiogram
CCC-A: Certificate of Clinical Competence-Audiology	ELM: Early Language Milestones test

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EMH (EMR): Educable Mentally Handicapped (Educably Mentally Retarded)	MD: Medical Doctor
ENT: Ear, Nose, and Throat specialist	MDI: Mental Development Index
ERIC: Educational Resources Information Center	M Ed: Master of Education
FAS: Fetal Alcohol Syndrome	MHB: Mental Health Board
FM: Fine Motor	MLU: Mean Length of Utterance
GM: Gross Motor	MS: Master of Science
HCEEP: Handicapped Children's Early Education Program	MSW: Master of Social Work
HEW: Health Education and Welfare	NICU: Neonatal Intensive Care Unit
IDPA: Illinois Department of Public Aid	OT: Occupational Therapy/Therapist
IDPH: Illinois Department of Public Health	OTR/L: Occupational Therapist Registered/Licensed
IEP: Individualized Educational Plan/Program	PDI: Psychomotor Development Index
IFSP: Individualized Family Service Plan	PDMS: Peabody Developmental Motor Scales
IQ: Intelligence Quotient	PhD: Doctor of Philosophy
ISBE: Illinois State Board of Education	PIE: Parent-Infant Educator
ITPA: Illinois Test of Psycholinguistic Abilities	PKU: Phenylketonuria
K-ABC: Kaurman Assessment Battery for Children	PPVT: Peabody Picture Vocabulary Test
LD: Learning Disability	PT: Physical Therapy/Therapist
MA: Master of Arts	RAP: Resource Access Project
MA: Mental Age	RD: Respiratory Distress
MAI: Movement Assessment for Infants	REEL: Receptive and Expressive Emergent Language scale
MAP: Miller Assessment for Preschoolers	RIDES: Rockford Infant Developmental Evaluation Scales

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RLF: Retrolental Fibroplasia

RN: Registered Nurse

ROP: Retinopathy Of Prematurity

RSV: Respiratory Syncytial Virus

SI: Sensory Integration

SICD: Sequenced Inventory of Communication Development

SIPT: Sensory Integration and Praxis Test

SOMPA: System of Multicultural Pluralistic Assessment

SP: Speech Pathologist

SSI: Supplemental Security Income

ST(SLT): Speech Therapist (Speech and Language Therapist)

SW: Social Worker

TMH (TMR): Trainable Mentally Handicapped (Trainable Mentally Retarded).

TOLD: Test Of Language Development

TORC: Test of Reading Comprehension

VMI: Visual-Motor Integration

WIC: Women's Infants and Children's nutrition program

WISC-R: Wechsler Intelligence Scale for Children - Revised

WPPSI: Wechsler Preschool and Primary Scale of Intelligence

